

INFORMED CONSENT: THE ROLE OF CONSUMER
CHOICE IN IMPROVING THE QUALITY OF
HEALTH CARE

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Information Consent: The Role of Co...

HEARING
BEFORE THE
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY
OF THE
COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
FIRST SESSION

WASHINGTON, DC, JUNE 28, 1993

Printed for the use of the Committee on Small Business

Serial No. 103-28



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CONTENTS

| | |
|------------------------------------|-----------|
| Hearing held on June 28, 1993..... | Page 1 |
|------------------------------------|-----------|

WITNESSES

MONDAY, JUNE 28, 1993

| | |
|--|----|
| Bennett, Avis and Mark, Dover, NH..... | 5 |
| Cooney, Bente, Chair, Working Group on Consumer Information, Coalition for Consumer Protection and Quality in Health Care Reform..... | 46 |
| Hannan, Edward, Ph.D., consultant, the New York State Health Department.. | 30 |
| Miller, Mary and Tom, Putnam, CT | 9 |
| Mohlenbrock, William, M.D., cofounder and medical director, Iameter, Inc. | 32 |
| Perez, Josefina, Homestead, FL | 12 |
| Schneider, Martin, publisher, Health Pages..... | 28 |
| Sessa, Ernest J., executive director, Pennsylvania Health Care Cost Contain- ment Council | 34 |
| Shearer, Gail, manager, policy analysis, Consumers Union..... | 44 |
| White, Robert I., Jr., M.D., professor and chairman, Department of Diagnostic Radiology, Yale University School of Medicine | 14 |
| Wittkin, Laura, executive director, National Center for Patients' Rights | 52 |
| Wolfe, Sidney M., M.D., director, Public Citizen's Health Research Group | 49 |

APPENDIX

| | |
|---|-----|
| American Dental Association, statement submitted for the record..... | 259 |
| Opening statements: | |
| Bilbray, Hon. James H. | 67 |
| Combest, Hon. Larry..... | 65 |
| Wyden, Hon. Ron | 62 |
| Prepared statements: | |
| Bennett, Avis and Mark..... | 68 |
| Cooney, Bente, with attachment | 231 |
| "Minimum Requirements for Consumer Information," draft white paper | 237 |
| Hannan, Edward, Ph.D., with attachment..... | 179 |
| "Coronary Artery Bypass Graft Surgery," report..... | 184 |
| Miller, Mary and Tom | 75 |
| Mohlenbrock, William, M.D., with attachments..... | 197 |
| Charts | 206 |
| Perez, Josefina | 79 |
| Schneider, Martin, with attachment | 98 |
| "Health Pages," magazine | 108 |
| Sessa, Ernest J. | 211 |
| Shearer, Gail, with attachment..... | 216 |
| Chart | 228 |
| "Health Care in Crisis," pamphlet..... | 229 |
| White, Robert I., Jr., M.D., with attachments | 82 |
| HHT Foundation International, Inc., summary for July 1992 meeting. | 85 |
| Physician's Guide to Rare Diseases, Jess Thoene, M.D..... | 90 |
| Wittkin, Laura | 250 |
| Wolfe, Sidney M., M.D..... | 245 |

INFORMED CONSENT: THE ROLE OF CONSUMER CHOICE IN IMPROVING THE QUALITY OF HEALTH CARE

MONDAY, JUNE 28, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 2359-A, Rayburn House Office Building, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The subcommittee will come to order.

Today, the Subcommittee on Regulation, Business Opportunities, and Technology will examine what will certainly be one of the bed-rock issues in the debate over health reform legislation: The issue of consumer choice. This is a make-or-break concern for the tens of thousands of small businesses and their employees and dependents on the eve of formal launching of the national health reform debate.

The freedom to choose one's medical providers will be a litmus test for any successful health reform plan that is proposed in this Congress. Making sure that Americans' first taste of health reform does not include the bitter flavor of Soviet-style barriers to free choice is absolutely essential.

So far in this debate, every serious health care reform proposal has relied on the principle of informed consumers making cost-effective choices. Consumers will be asked to take more responsibility for the cost and quality of the health services they purchase. I certainly support these goals. Whether the reformed health care market heals and comforts people, or sucks them down in a sink hole of inaccessible, poor quality care, will depend to a great extent on the quality of comparative information that is available to consumers, doctors, and purchasers.

No matter how elegant the new health care system is in its conception, it won't work if it is built on top of a rotten foundation of skimpy and fragmented information as to cost and quality. At the very least, the consumer has a right to know which health care providers they should avoid. Unfortunately, today, Americans have access to more product performance information when purchasing breakfast cereal than when choosing a heart surgeon. Governmental barriers to informed choice, in particular, are everywhere in today's health system. Today, the subcommittee will hear about it.

First, consumers are being denied access to information in the Government's possession that would reveal whether the doctor treating them is 1 of the 7,000 doctors disciplined by a medical licensure board or a hospital peer review committee in the United States during the past 2 years. This information is contained in the National Practitioners' Data Bank, but the consumer, whose taxes are deposited in the Treasury to pay for the data bank, is not allowed to withdraw information from it.

Second, the subcommittee will hear testimony this morning that 37 States gather information on costs and quality, but only 3 of them will allow the public access to this information. In fact, the genesis of the landmark New York State report on coronary artery surgery success rates was a lawsuit won by Newsday newspaper, which had been denied access to this same information.

Federal health reform law should demolish these anticompetitive, governmental barriers to well-informed consumer choice.

For example, there is no logical argument for denying the public the names of doctors who have paid multiple malpractice payments over a short period of time, or who have been sanctioned through hospital disciplinary actions or State licensing boards. As the principal sponsor of the legislation creating the data bank, I intend to push for enactment of a new law providing consumers with access to this essential information.

Opening the data bank will help consumers avoid some of the worst providers and repeat offenders that we will hear about from the first two witnesses this morning. But consumers need to know that quality of care is much more than the mere absence of documented gross or repeated negligence.

The Harvard Medical Practice studies show that only one in eight instances of negligence ever result in a malpractice suit being filed, must less won by the plaintiff. Plaintiffs win five times as many malpractice lawsuits as the number of instances in which negligence results in a license revocation or suspension of hospital privileges.

This means, in short, that additional measures of quality are needed. Consumers must have easy access to comparative information on plans, providers, and the success rates of the treatments they provide. This is no radical, futuristic concept. The last Congress passed, and President Bush signed, legislation I sponsored to publish infertility clinic pregnancy success rates, so consumers can choose which clinic, if any, to invest with their hopes and their cash.

Building on this precedent, this morning, a coalition of over 30 national consumer groups will testify that they want a "report card" disclosing key quality measures, like the percentage of young children in a health plan who have received all appropriate immunizations, or the proportion of a cardiac surgeon's bypass patients who survived for a year. Consumers would use these report cards to decide which health plan to enroll in and which providers to use when they need treatment.

These consumer groups and the organizations that they work with have made it very clear to me that they think there is something very wrong when it is possible for people to find out more

product performance information about a cereal than they can get when they chose a heart surgeon.

Government is not the only source of barriers to informed choice. Today, the subcommittee will hear repeated accounts of Kafkaesque bureaucracies erected by managed care organizations as a barrier to prompt and appropriate treatment. Witnesses will testify this morning of Health Maintenance Organizations [HMO's] literally heaping insult on top of injury, first by providing unsatisfactory service, and then by refusing to pay for timely care that their desperate enrollees manage to find outside of the HMO.

The poor quality and cavalier behavior of some of these organizations is nourished and protected by their ability to lock in patients to using only the health plan's providers, even when those providers are unwilling or unable to do what is needed. By forcing consumers into entering into year-long contracts with these plans, the HMO is shifting risk to its enrollees and letting consumers bear the burden of its mistakes.

The Chair does believe that there are alternatives. For example, there is the point of service HMO. These organizations allow consumers to use out of network non-HMO providers, recognizing that they may cost a little more to the consumer out-of-pocket.

The evidence shows that few patients in well-run point of service HMO's seek out-of-network services. Obviously, when consumers have real freedom of choice, as they do under the point of service program, plans must be more responsive or, in effect, they lose control of their business.

It is also worth noting that the point of service plans appear to draw most of their subscribers from costly and inefficient indemnity health insurance plans. More importantly, this alternative shows that you can have real consumer choice and cost containment in peaceful coexistence.

The Chair believes that protecting the rights of consumers will have special benefits for small businesses. These health purchasers are hungry for comparative information on the quality of medical providers, so they will know who to contract with, and who to refer their employees to, for the best results. Small firms are telling this subcommittee they are anxious to work with us on this important issue, and we intend to take them up on their offer.

We have an excellent panel of witnesses today, but first I want to introduce two of the activist members of our subcommittee who have been particularly helpful on these matters relating to health costs and small businesses and first recognize our ranking minority member, Mr. Combest.

[Chairman Wyden's statement may be found in the appendix.]

Mr. COMBEST. Thank you, Mr. Chairman. I would like to thank you for calling this hearing on what I feel are some of the most complex and controversial issues that we must confront in trying to reform the Nation's health care system. We all agree that "bad doctors" do exist, and I think we all agree that immediate steps have to be taken to ensure that tragedies like the ones we will hear this morning are not duplicated.

I know that some here today, including the chairman, advocate allowing consumers to have unparalleled access to information on health care providers. I certainly would agree that as part of the

overall effort to reform the health care system a better informed consumer will be essential to ensure higher quality care while keeping health care inflation down. But, Mr. Chairman, like so many problems that we deal with in Congress, the problems are so much easier to identify than the possible solutions.

As the congressional leader in establishing the National Practitioners' Data Bank, I believe that you are keenly aware of both its strengths and weaknesses. As I understand it, the data bank has been collecting and maintaining data on medical liability claims and adverse actions taken against health care professionals since September 1990. While only doctors who have had settlements for malpractice claims are listed on the data bank, the fact that a settlement has occurred may have little relation to whether there actually was negligence.

In this hyperlitigated society, the typical physician has a 38-percent chance of being sued for medical malpractice, and, if they practice surgery, this increases to over 50 percent. The average OB/GYN can expect to be sued at least three times during their career.

Currently, the information on the data bank can only be accessed by hospitals and accrediting medical boards that have the ability to sanction physicians. While I believe efforts to increase access to health care information for consumers is important, we must work to ensure that we do not further alienate the medical community. At a time when many physicians feel that the Federal Government is overly micromanaging their occupation, it is essential that policymakers work hand-in-hand with doctors. If not, I believe comprehensive health care reform will not be possible.

Mr. Chairman, in closing, let me thank you for your efforts in the health care reform debate. I look forward to finding some solutions to the many difficult problems presented before this subcommittee.

[Mr. Combest's statement may be found in the appendix.]

Chairman WYDEN. Let me thank the gentleman for an excellent statement. I think he knows that these issues require great care, and we intend to pursue them in a bipartisan way, as this subcommittee has always done its work. I thank the gentleman for an excellent statement.

Let me recognize my friend from Nevada, the chairman of another subcommittee of the Small Business Committee, who has also been very active and outspoken, a leader in this area, Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman. I am not going to give my full statement. I would like to have it put in the record.

I appreciate the chairman addressing this problem because as soon as the budget conference is completed and President Clinton's program is passed unanimously by both Houses, we will begin addressing this serious problem.

I think for the balance of the 103d Congress, at least the first session, we certainly will be into this matter. I am anxious to hear the witnesses today because, as well as the ability to choose, I think we have to make sure the patients have the ability to know what they are choosing.

I agree with Mr. Combest, the ranking minority member, that the medical profession has to be a critical part of this process. Fail-

ure to bring the doctors and the hospitals into the process will result in a failure of this program. At the same time, the patients are the number one concern of this Congress and the people who serve in it.

I appreciate your having this hearing. I will put my entire statement in the record. I am anxious to hear the witnesses today and the continuation of these hearings, as I know you will progress throughout the year.

Chairman WYDEN. Without objection, the gentlemen's statement will be entered into the record at this point. We want to thank the gentleman for all the work he has done over the years with our subcommittee.

[Mr. Bilbray's statement may be found in the appendix.]

Chairman WYDEN. Let's go to the first panel, Mrs. Avis Bennett, Dover, New Hampshire; Mary Miller, Putnam, Connecticut; Josefin Perez, Homestead, Florida; and Robert I. White, Jr., M.D., Yale University, New Haven, Connecticut.

Now we called up four, and we produced six. Let me make sure of who's who. The Bennetts have come together, Mr. and Mrs. Miller are here, Dr. White, and Mrs. Perez. We welcome all of you.

Let me say since we have a couple of spouses here among the Bennetts and Millers, and you all will be taking questions, it is the practice of this subcommittee to swear all the witnesses who come before the subcommittee. Do any of you have any objection to being sworn as a witness?

[Witnesses sworn.]

Chairman WYDEN. We are going to make your prepared statements a part of the hearing record in their entirety. I know that there is almost a biological compulsion to read one's statement. If we might persuade you in your 5 minutes or so to just talk to us and tell us your thoughts and your concerns, it would be very helpful, and we will put your entire statement into the record.

Why don't we begin with you, Mrs. Bennett?

TESTIMONY OF AVIS AND MARK BENNETT, DOVER, NH

Mrs. BENNETT. Good morning. I am Avis Bennett, and this is my husband, Mark. We reside at 44 Summer Street, Dover, New Hampshire. We are grateful to be here today to share our personal story about the devastating consequences that happened to us because we were denied the ability to make an informed choice about a medical practitioner.

We became involved in this issue because of events that happened in 1984. That was the year my husband, I, and our three children moved to Dover, New Hampshire, a small eastern seacoast community. Our daughter Heather, who was 3½ years old at the time, had been born with a large cyst in her brain. The cyst had only allowed one quarter of Heather's brain to develop. The doctors inserted a shunt, which is a device placed in the skull to allow excess fluid to drain down from the cyst through a tube. The tube would carry the fluid away from her brain, down her neck, over her chest and into her stomach cavity where it was absorbed.

Heather's prognosis was grim. We were told that in all likelihood she would be severely retarded, and that we should consider insti-

tutionalizing her. But Heather was our miracle child. She grew up achieving all the normal milestones.

When we moved to New Hampshire, we were elated to discover that there was a neurosurgeon only minutes from our home, Dr. Stephen O. Dell.

Although Heather was doing beautifully, having no trouble with the shunt, we knew she needed to be under a neurosurgeon's care for periodic checkups. We were also aware that as Heather grew, the tubing that had been coiled in her stomach would shorten and eventually need to be replaced with longer tubing.

We scheduled our first visit with Dr. Dell in May 1984. He was very impressed with Heather's progress, as was I with Dr. Dell's credentials. His office walls were lined with certificates from a number of very prestigious universities, and he told me that he had just been accepted into a pediatric neurological society. I also noticed from the sign outside his door, that he had both an M.D. and a Ph.D.

During that first exam, we discussed the shunt lengthening procedure. When I asked Dr. Dell if he had done this procedure before, he laughed and said he had done this surgery more times than my "country" doctor in Vermont would ever see. I took his response as a definitive "yes," knowing that my doctor in Vermont had taken care of many pediatric shunts.

When I asked about the risks of doing the procedure, he told me that there was a 99.9 percent chance of no problems. Dr. Dell had answered all my questions, and I felt very confident about going through with the surgery and comfortable with him as Heather's physician.

On July 9 at 6:00 a.m., Heather, my husband, and I arrived at Wentworth-Douglass Hospital. After surgery Dr. Dell finally came out to the waiting room to assure us that all had gone well. At that point, he introduced us to a Dr. Prostkoff, who he explained had assisted him with Heather's surgery.

My husband and I decided that I would spend the afternoon with Heather, and he would go home to be with our two boys.

When Heather first got back to her room she was doing great. She was alert and awake, busily describing the bubble gum anesthesia she had been given. About 40 minutes later, however, she began to vomit. As the afternoon wore on, Heather complained of headaches and slept between her hourly episodes of vomiting.

No neurological vital signs were ever taken on Heather, and the only contact I had with Dr. Dell was late that afternoon when he called when Heather was to be released and recommended that she spend the night.

My husband decided to come back to the hospital to relieve me for awhile. As I was waiting for him, I remember thinking these are all signs of a blocked shunt. There is a small valve located at the back of the shunt to help drain the fluid if there is a problem, but it is only to be pushed in an emergency. I was about to push it, but unfortunately stopped myself at the last moment thinking that I was surrounded by medical professionals and two neurosurgeons who would surely recognize if Heather was having a real problem and take the appropriate steps.

So, when my husband arrived, I reassured him, as Dr. Dell had reassured me, that Heather was just having a reaction to the anesthesia but would be fine by morning.

At midnight, as my husband was laying his head down by Heather, he noticed bubbles coming out of her mouth. Heather had gone into respiratory arrest. An emergency team was called in and revived her, but as they were reviving her she began to vomit, breathing it into her lungs, causing a severe case of aspirated pneumonia.

We were told that when Dr. Dell arrived in the intensive care unit, he cut Heather open without anesthesia, pulled out her tubing, and cerebral fluid, which had been trapped by the blockage, sprayed all across the room.

Heather had shown all the classical signs of a shunt blockage or intracranial pressure. Dr. Dell had ignored them.

By morning, Heather began going into severe seizures. Her body, her arms, and her legs jerked uncontrollably. She was drooling from the sides of her mouth. Her eyes were rolling in her head.

I could not believe this was the same precious little girl, someone who could make all my difficult times bearable by just saying, "I love you, Mommy." I had promised her the doctors and I were going to take very good care of her. Now, as I watched her being destroyed before my eyes, I began to blame myself for letting this tragedy happen.

At noon, Heather's heart stopped beating. I asked Dr. Dell how this could happen. I brought in a healthy, beautiful, little girl, and, 24 hours later, she was dead. He informed me it was not his fault. The nurses had never related to him all of her symptoms. That would only be the first of many lies in which Dr. Dell was caught. Heather's record had clear documentation of many calls made to him by the nursing staff. In fact, as a result of one of those calls, he prescribed Tylenol for a headache.

After Heather's death, we uncovered many problems with Dr. Dell's background, skill, experience, and moral character. We learned that despite his claim about having experience with pediatric shunts, he had never done that procedure before at Wentworth-Douglass, and we could find no evidence that he had ever performed this procedure in the 4 years prior when he worked at the Veteran's Hospital in Boston.

We also learned that the physician Dr. Dell introduced as the "assistant" surgeon, had, in fact, never assisted with Heather's surgery. When Dr. Prostkoff was deposed, he stated that he was not in the O.R. that day, and that he had not dressed or scrubbed for the surgery.

We were also stunned to learn that Heather never needed the surgery at that time. In fact, the tubing ended up being shorter after Dr. Dell's surgery. We also uncovered the fact that Dr. Dell had lied about many of his very outstanding credentials that impressed me. He never received a Ph.D. from Princeton as he claimed. He was never awarded a degree from Oxford, as he claimed. He never received a degree in mathematics from Harvard, as he claimed.

Mr. BENNETT. In the years since Heather's death, we have learned so much about Dr. Dell, both as a physician and a human

being, and it horrifies us that he is still out there practicing. Much of the blame, however, can be traced back to the profession itself and the physician oversight systems which have enabled dangerous doctors like Stephen Dell to continue harming and killing innocent patients.

Dr. Dell holds licenses in seven States: New Hampshire, New York, California, New Jersey, Vermont, Maine, and Massachusetts. His medical offenses can be traced to the beginning of his practice.

Although he came to Wentworth-Douglass Hospital in 1982 with glowing recommendations from the Tufts New England Medical Center in Boston, where he had worked from 1978 to 1982, Wentworth-Douglass Hospital later learned that Dr. Dell had, in reality, been forced to leave Tufts. He was found to have been an inadequate technician, both in terms of diagnosis and surgical skill, he had problems with interpersonal relationships, and he had an unacceptable level of morbidity for certain procedures he performed.

Dr. Dell also had problems at Wentworth Hospital during his entire tenure from 1982 to 1988. In 1988, prompted by our attorney's discovery about the lies on Dr. Dell's curriculum vitae, Wentworth finally suspended his privileges. In doing so, they cited that he was flagrantly insensitive, careless, and dishonest. He had poor relationships with several departments. He repeatedly failed to provide coverage for his patients when he was away for the weekend. He falsified documents. He lied to his patients, and was found to have been responsible for the poor outcomes of 15 patients, including 3 patient deaths. He has also been sued at least nine times for medical malpractice.

After Dr. Dell lost his privileges, the New Hampshire Board of Medicine initiated an investigation of Dr. Dell, but instead of looking at the 15 patient harm cases still well-documented by Wentworth-Douglass, the board decided to take the easy way out.

According to the attorney for the medical board, an understanding had been reached between Dr. Dell and the board in which Dr. Dell would no longer attempt to practice in New Hampshire if the board did not revoke his license. Dr. Dell had convinced the board that he wanted to move to Texas but would be unable to if the misconduct charges in New Hampshire were too severe.

So, New Hampshire merely required Dr. Dell to complete a medical ethics course and formally acknowledge to the hospital and a patient that he had lied before renewing his license. New Hampshire expected Dr. Dell to become some other State's problem, but the plan backfired.

Thanks in part to our efforts, Dr. Dell was unable to get a license in Texas, and returned to New Hampshire seeking to reinstate his license. The State has reopened his case, and is finally looking at the pattern of patient harm.

In the meantime, in late 1990, Dr. Dell went to New York and was granted temporary privileges at Brookdale Hospital. In February 1991, however, Brookdale terminated his temporary privileges and refused to grant him permanent privileges because of apparent problems with his performance.

Dr. Dell holds licenses in seven States. In 1992, the Vermont State Medical Board disciplined Dr. Dell, and New York's Medical Board is in the process of disciplining him at this time.

Although Massachusetts was aware of the actions against Dr. Dell, they just recently allowed him to renew his registration to practice medicine in that State. Even though he has been unable to get hospital privileges, it has not slowed him down. He has already set up five private clinics across Massachusetts and is currently working there. It is conceivable that because he holds licenses in so many States, it might take years before he is finally stopped from practicing.

Nothing will ever bring Heather back, but if someone had spoken up about Dr. Dell beforehand, our daughter might be alive today. Our family lives with the pain of losing Heather every day. It is a pain we do not wish on any parent. Medical consumers must be allowed to have access to the National Practitioners' Data Bank in order to make truly informed decisions about their medical care. This is not an issue of revenge; it is an issue of public protection.

The public has a right to know about Dr. Dell's pattern of dangerous, unprofessional, and unethical care. Our tragic experience has shown that we cannot rely on a hospital or oversight agency to protect us from harm.

[Mr. and Mrs. Bennett's statement may be found in the appendix.]

Chairman WYDEN. Thank you both very, very much, most especially for just being willing to come and speak to us.

I have a 4 year-old, and I have a 9 year-old. I am not sure I could come before a congressional subcommittee and talk as you all have. I am going to have a few questions in a minute. Your willingness to be here to speak makes it less likely this sort of thing will happen again. We are going after these problems. We appreciate your being here.

Mr. and Mrs. Miller.

TESTIMONY OF MARY AND TOM MILLER, PUTNAM, CT

Mrs. MILLER. Good morning. My name is Mary Miller. This is my husband, Tom. We are from Putnam, Connecticut. We would like to take the time to thank you for the opportunity to speak with you this morning.

In December 1991, I made an appointment with Dr. Steven Ira Weber. Dr. Weber had only just moved into the area and had taken over my former physician's private practice.

My initial complaints were of a minor gynecological problem, a yeast infection or possibly a urinary track infection. Upon examination, Dr. Weber found a cervical polyp, which he wanted to schedule an appointment to remove. The appointment was scheduled for January 6 when he removed the cervical polyp and performed an endometrial biopsy, which is taking a sample of tissue from your endometrium.

His nurse called me at work, 10 days later, and asked me to go back into the office for more blood work, stating that there was a problem with the biopsy. I left work that afternoon and went to his office and had blood work taken again. I asked his nurse if there was anything to be concerned about. She told me Dr. Weber would explain everything to me. When I asked him what the problem was with the biopsy, he told me my estrogen level was a little elevated,

nothing to be concerned about, and the blood work was just routine.

The following day, I was called again at work and told he needed to perform another procedure on me and could I please come back to the office that day. I went back in and Dr. Weber told me he was going to remove the remaining tissue from my endometrium. When the procedure was over, he told me that what he had done was a mini-D&C.

The following night was a Saturday night, and I began bleeding vaginally quite heavily, and I became concerned. I called Dr. Weber's service and was told he was off for the weekend. My husband took me to our local emergency room. I was seen by the emergency room physician and a visiting fellow from Yale-New Haven. It was there after blood work taken in the emergency room that I was told for the first time that I was pregnant. I was shocked. I had a history of infertility. I had numerous surgeries to unblock fallopian tubes and had been told that I would be unable to conceive.

We asked to come in the following day for an ultrasound to see if the pregnancy was still intact. We went in on Sunday morning, had the ultrasound done, and we were told that due to the mini-D&C and possibly the endometrial biopsy the pregnancy had been lost.

My husband and I were in shock and wondered how this could have happened, had Dr. Weber known I was pregnant, and, if he did, why didn't he ever tell us?

On Monday morning I gathered all my records from the hospital, and I went to see Dr. Weber. I asked him what had happened. He told me at that time that the blood work that he had done on me was actually a pregnancy test. The pregnancy test came back stating that I was between 5 and 6 weeks pregnant, but he did not feel it was a viable pregnancy so he didn't tell me.

Because of the complexity of the case, the emergency room at our local hospital and the chief of staff contacted the Connecticut Medical Board. The hospital suspended his privileges in the hospital and the Connecticut State Medical Board summarily suspended his license.

Upon speaking to the attorney for the State of Connecticut Medical Board, we found out for the first time that Dr. Weber's license had been revoked in the State of New York for several charges of gross negligence.

At the time that he held the New York license, he also held a Connecticut license and on weekends and spare hours would travel to Danbury, Connecticut, to work in a family planning clinic performing abortions. We asked the State medical board why they allowed him to practice in the State of Connecticut. We were told that he had never had any complaints filed against him in Connecticut so that he would be allowed to work in our hospital under supervision. The problem with that was that there was no one to supervise him in his office where he did these procedures.

We also learned that Dr. Weber received his medical license in Mexico at a school that had been investigated for the ease in which you could enter and receive your medical license.

No one ever came forward with this information. Our local hospital knew of his background and knew that his license had been revoked. When we were asked pertinent questions about my health and well-being, we were lied to. Because of the lies that he told, we were never given the opportunity to get a second opinion or to give informed consent for the procedures that he did.

If we had been able to have access to the National Practitioners' Data Bank, we would have seen this was not a doctor who made one or two mistakes in a life-long career, but a relatively young doctor who caused a number of his patients to suffer devastating harm and losses and whose medical license had been revoked in another State. There was no question but we would have stayed away.

Mr. MILLER. Gentlemen, good morning. When I got involved in all the proceedings here it was already when we knew something was wrong, and we started working within the legal system of the State of Connecticut Medical Board to hear reasons why his license should be revoked. We thought we were finding out this information all at the same time. In other words, we found out about the New York action at the same time that Connecticut had found out about the New York action, and at the same time that our local hospital had found out about the New York action.

We were suddenly made aware that both of those organizations that we had trusted to provide a health care provider in our community had already known about the New York action and had made plans to put him on probation and accept him anyway.

The fact that it was a unanimous decision by the 12 board members in Connecticut was their way of correcting a mistake. They realized that the 13 counts contained in the New York decision were sufficiently important enough, but not important enough at the time they allowed him to take up his practice in our community, but, in hindsight, important enough to revoke his license in the State of Connecticut, and the information from the data bank was, in fact, reviewed, but not acted upon. That is something I will never understand.

The pivotal testimony in our Connecticut license revocation hearing was whether or not Dr. Weber received informed consent. There were procedures performed. The consent forms were signed. The consent forms signed, however, were for procedures that were written and represented to be one procedure but, in fact, were another. For that reason, we could not make informed consent.

Frankly, there were some procedures that he never even bothered with a consent form. So, we really had no way of being responsible other than having the information be made available to us directly and letting us make the choice of who provides our health care. There will be instances, both statewide and locally, in which these things will get through the gaps.

Thank you very much.

[Mr. and Mrs. Miller's statement may be found in the appendix.]
Chairman WYDEN. Thank you both as well.

This subcommittee has taken a special interest, as you may have heard earlier, in matters relating to fertility, and to hear you all describe the trauma you have gone through is especially important. We are very hopeful that fewer couples are going to face this, both

in terms of the fertility clinic legislation that passed last session and also what you described in items of making sure people, when they need to make a decision about a doctor, can get access to at least as much information as they get for other purchases which are much less important than the ones you both have made.

We appreciate your coming. I will have some questions in a moment. I think what you have told us has been very helpful.

Let's now go to Ms. Perez. Ms. Perez, we welcome you. Thank you very much for coming.

TESTIMONY OF JOSEFINA PEREZ, HOMESTEAD, FL

Ms. PEREZ. My name is Josefina Perez. I am from Homestead, Florida. I am a single, working parent. I am also a Medicaid recipient with four minor children in my home. We are enrolled in the community health plan HMO.

We were allowed to choose our own HMO. During the evening of September 24, 1992, I went to the emergency room at South Miami Hospital in Homestead because I was bleeding and having contractions. I had not had a period in 3 months, and assumed I was pregnant. I had two positive pregnancy tests before I went into the emergency room.

The HMO was closed at that time. On September 29, 1992, I did miscarry. This was confirmed by the gynecologist I saw later that day who reviewed my earlier blood test and did an ultrasound. The HMO is now refusing to pay the bill from the emergency room.

In December 1992, I took one of my daughters to the emergency room because she had had a fever for 3 days, and when the fever broke her mouth was full of bleeding sores. She was bleeding so badly from her mouth that she had been able to drink or eat very little for the past few days. Again, it was in the evening, and the HMO was closed.

Before taking my daughter to the emergency room, I had called the HMO during the day and was told that the doctor was on vacation, and that I should go to the emergency room. The emergency room registrar called the HMO for approval and was told that this was not an emergency, and my daughter could not be seen. The hospital registrar told me to call the HMO to see if I could reason with them. I called the HMO and asked to speak with the approver, and the answering service said I was not allowed to do so, that only hospitals and HRS's were allowed to speak to approvers, not clients.

I asked the answering service operator if she could deliver the approver a message to see if my daughter could be treated at the emergency room, because she had been bleeding badly from her mouth and she was unable to eat or drink with all the blood. She said I would have to wait until Monday when her regular doctor came in. I protested that she would have to wait 3 more days and was not able to eat or drink, and the HMO still refused to let her be seen.

The hospital called the HMO back because they saw my daughter was in pain, and the HMO still refused to treat her. The hospital told me I would have to give them money up front which I did not have.

I called the HMO back and asked the operator for her name. She told me it was "none of my damn business" and hung up on me. I went home and treated my daughter myself with medicine which my son had been taking. He then ended up getting sick again.

On the following Monday, I called the HMO and told them what happened the previous Friday evening, and I was told they would take care of it. I also told them I wanted to disenroll from the HMO, but the HMO insisted this would not happen again.

I also told them they had not been paying the bill for my emergency room treatment in September because I was getting the bills. The HMO denied the fact that they were not paying the bills. They told me to photocopy the bills and send them to them. I did so, and the bills have still not been paid.

In December, I called the number on the back of the card regarding complaints. The lady that answered the phone told me that she could not speak to me and that I should talk to my HRS worker. She hung up on me.

I called the HMO again to speak with a supervisor about my problems and was told that the reason the hospital bill was not paid was that the hospital did not seek approval from the HMO before I was seen, so I had to pay the bill.

I also have a daughter who had chronic ear infections for 6 months. She finally received approval to be seen by a specialist. However, the specialist's office is in Hallendale. I live in Homestead, which is over 1½ hours away. Since I do not know my way around that area, I called the HMO for their van service and stayed home from work a half day in order to wait for the van. The van never came.

When I asked for a new appointment with the specialist since the van never came, I was told that I would not get another approval since I missed the first appointment with the specialist.

In April, one of my daughters fell and injured her face. I called the HMO and was told that her doctor was on vacation. I asked if I could take her to the emergency room and was told no, that I could not. The HMO receptionist said she would call back with the name of another doctor but she never did. I continued calling a number of times but the HMO never called back with a referral. My daughter's face was badly swollen, and she had trouble breathing. She was unable to go to school, and I had to miss work in order to stay home with her.

Around the same time another daughter got an ear infection. Again, I was told her doctor was on vacation so I asked for another doctor. The HMO receptionist said she would call back. I called back two times, left the same message, waited at home all day, and never received a call back.

After the doctor came back from vacation, I called him again, and he told me that she would need an appointment to see him, and that since no appointments were available for a while she should go to the emergency room. I then took her to the emergency room for treatment. The emergency room is now billing.

I began trying to get disenrolled from the HMO in February and was not disenrolled until May.

So, for me the problems are clear. We are not in a very good area because of the storm, and kids are more likely to be injured. There

is a lot of debris and trash in the area. A lot of viruses were going around. I make very little money. I cannot even begin to afford to pay for a bottle of medication at this time, unless I take another full-time job. I let them go the first time after I lost the baby. They don't want to pay for any treatment. For them, it is not an emergency. You have to wait 2 or 3 weeks for a doctor's appointment in these programs, and they don't want to talk to you. They hang up on you. They say we have no right to call them, to talk to our HRS worker. We signed up for this program, not the HRS worker. We chose them to be our HMO, but they won't speak to us, and they treat us very badly. That is all I have to say.

[Ms. Perez' statement may be found in the appendix.]

Chairman WYDEN. Thank you very much for coming.

Chairman WYDEN. Ms. Perez, we have had a number of witnesses over the years talk about health issues and rarely have they put it as bluntly, as directly, and as clearly as you have.

I want you to know, if there is one thing that health reform is going to stand for, when Congress is through working on it, it is that it is certainly part of the consumer's business and the obligation of these providers to tell you when somebody is considering approving or denying a service.

To have an insurance provider tell you that it is none of your business, when you literally have a life or death matter on the line with respect to getting a service approved, is just unacceptable. We are going to make darn sure that this crowd of powerful medical interests, the gang that has always decided things, knows that it is going to be part of your business and your right to know in the future.

Thank you for some excellent testimony. I know my colleagues will have some questions here in a moment.

Chairman WYDEN. Dr. White.

TESTIMONY OF ROBERT I. WHITE, JR., M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF DIAGNOSTIC RADIOLOGY, YALE UNIVERSITY SCHOOL OF MEDICINE

Dr. WHITE. Thank you for the opportunity to speak with you about patients with rare disorders who are having difficulty getting appropriate care through HMO's. Rare disorders are not so rare when you consider that 1 person in 12 has a condition which may require specialized care.

My name is Robert I. White, Jr., and I am an interventional radiologist; that is to say, I perform image-guided procedures without surgery, euphemistically known as surgery without a knife. As such, our patients spend an average of 24 to 48 hours in a hospital and have no significant postprocedure recovery.

I am also the chairman of Diagnostic Radiology at Yale University School of Medicine, chief of the Section of Diagnostic Imaging, Yale-New Haven Hospital, and chair of the medical advisory board of the HHT Foundation International. HHT stands for hereditary hemorrhagic telangiectasia, which is a rare disorder of the blood vessels affecting the nose, brain, lung, and intestine. It affects 50,000 Americans.

In a typical week, we spend between 5 and 10 hours in frustrating negotiations with HMO's and other managed care providers trying to help our patients through the system.

I would like to give you several examples. Carol K. is a 45-year-old Palo Alto, California teacher who has HHT. Her HMO refused to let her be treated at Yale New Haven Hospital. Today, she is requiring blood transfusions for anemia secondary to her gastrointestinal bleeding which is as a result of her disease. She is afraid to fight her HMO because she is concerned that she will lose coverage.

Lawrence M. is a 50-year-old Hartford, Connecticut man with a 3-year history of allergic reactions to iron infusions which he must take because of his anemia. He has refractory nosebleeds which last from 2 to 3 hours daily. He has severe gastrointestinal bleeding, anemia, and angina pectoris secondary to his disorder.

For the past 3 years, he has been followed by a Hartford HMO for this series of tests. He came to us for an evaluation at Yale after a great many frustrating delays by his HMO. In addition to diagnosis and treatment of gastrointestinal bleeding, he needed a specialized nasal operation, and, finally, we finally convinced the HMO that they needed to send him to Boston for nasal surgery. We had to threaten the medical director of the HMO with a lawsuit if the patient's care was less than optimal before the patient was permitted to go to Boston for his nasal operation.

Arlene R. is a 58-year-old woman with a brain abscess and a large pulmonary arteriovenous malfunction; that is, blood vessel malfunction of the arteries and the veins in the lung which can cause stroke, brain abscess, or excessive bleeding from the lungs. She was followed in Boston by a prominent physician at a well known HMO. They recommended surgical removal of the lung. This would have been a difficult operation costing two to three times the alternative, less invasive option.

The patient's son learned about HHT and the noninvasive therapy we use at Yale for treating pulmonary malfunctions, a technique which I developed which is similar in complexity to coronary balloon angioplasty, but instead blocks the abnormal blood vessels of the lung and takes twice as long to perform.

The patient came to Yale, and after many hours of negotiations with the HMO, we were able to admit and treat her with the non-invasive balloon procedure. She did not require surgery. There was no postoperative recovery. She was discharged within 48 hours and is doing well.

The real problems with HMO's trying to treat the 1 in 12 of us with a rare disorder are that they often lack the experience and physicians who have the expertise in specialized techniques needed for diagnosis and treatment of rare disease.

I would like to give just an overview for a moment, if I may, about rare diseases and our patients' needs. There are 5,000 rare disorders affecting 20 million Americans. This means that 1 in 12 of us has a condition that may require specialized care. A rare disease is defined as 200,000 or less affected individuals.

The examples of rare diseases include: Tourette's syndrome which the child psychiatrists treat at Yale, autism, Huntington's

disorder, cleft palate, spina bifida, Lou Gehrig's disease, and many others, including the one I am interested in which is HHT.

There are centers of excellence for treating rare disorders in this country, which I would define as a health care facility with a concentration of physicians and nurses seeing minimally 30 to 40 patients yearly with this rare disorder and with a proven expertise as demonstrated by articles published in peer reviewed journals.

Furthermore, most of us who are physician-specialists at centers of excellence with an interest in a specific rare disease which we study and treat, will often lower our own fees and lobby for the hospital to do the same in order to make specialized treatment affordable and available.

The National Organization of Rare Diseases is a highly effective advocacy group comprising a coalition of these nonprofit organizations representing rare diseases, and they are an excellent resource.

The recommendations I would make, or at least suggest you consider, would be to allow freedom of choice for patients with a rare disorder, that is, the ability to seek a diagnosis and treatment in a center of specialized expertise for managing their condition.

I also would agree with a point of service option, the opportunity for a patient with a rare disorder to seek an alternative care provider without the undue financial or other penalties such as loss of their insurance.

Finally, I would advocate for an ombudsman, who is an advocate for rare disorders, so that patients and physicians are provided with choices.

Managed competition and costs should be facilitated by a simple type of agreement so that patients do not lose treatment options or have a delay in their diagnosis during lengthy negotiations between insurance companies, hospitals, HMO's, physicians, and employers.

Routine referrals of rare disorders by HMO's and managed care practitioners to centers of excellence for rare disorders is well defined in the Physicians' Guide to Rare Diseases, a new book edited by James G. Thoene, MD, which has been published under the support of the National Organization of Rare Diseases by Dower Press. If people would read this, they would more than likely be able to afford and obtain cost- and patient-effective therapy.

I would like to thank you for allowing me to make a brief statement about access to health care for patients with rare disorders.

[Dr. White's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Dr. White, thank you.

Your testimony is very helpful and certainly a perspective that needs to be understood. You hear about rare disorders affecting 20 million people. As you spoke, this certainly means that it is not exactly something that happens occasionally but affects millions of Americans. It is helpful to know.

I am going to recognize my colleagues for their questions, but we are very pleased the gentleman from Massachusetts, Mr. Meehan, has joined us. I want to recognize him first if he may have any opening statement he would like to make.

Mr. MEEHAN. Very briefly, I just want to commend all of the panelists. I am a new Member of Congress, and before I got elected to Congress, I was a prosecutor up in Massachusetts. I have spent a lot of time trying to deal with the health care issue and have had three conferences in Massachusetts. I hear a lot about defensive medicine and the difficult situation that the medical profession is in because of the demands on consumers, and it really has been enlightening for me this morning to be here and to get another perspective.

So, I thank you and look forward to additional input. Thanks.

Chairman WYDEN. I thank my colleague. Let us begin the questioning with the gentleman from Texas.

Mr. COMBEST. Thank you, Mr. Chairman. I will also join the chairman in saying how much we appreciate what I am sure was very difficult for you. Mr. and Mrs. Bennett, I have scanned back through your testimony. Was the hospital where the physician was working aware of his past?

I know you mentioned he had sued them as well. There were a lot of faults. Were they aware of his lack of the credentials that he had so indicated and that he had also signed the name of the assistant physician? Had they any knowledge of his past?

Mr. BENNETT. When he first came from Tufts, all the doctors had sent glowing recommendations from where he came. One doctor from Dover had eventually called down after they had several problems with Dr. Dell and discovered that a couple of the people who had sent glowing recommendations actually stated that he was kind of forced to leave, and that was their way of getting rid of him.

Throughout his stay there, he was called in—I don't want to say reprimanded. He had several letters where he was caught signing that he had an assistant, when he didn't, saying that he just thought that this was a hospital requirement and our case actually happened at least 6 months after at least one of the letters that he had received telling him that he should not be doing this.

Mr. COMBEST. In your case, it was fairly blatant. I mean, the hospital had a very wide awareness of the problems that this physician had had.

Mrs. MILLER. Yes; they knew.

Mr. COMBEST. In both of those instances, by the time that you had seen these physicians, there was a fairly lengthy track record of problems. I think these are very blatant cases in which there would be absolutely no argument whatsoever that these doctors should not be practicing.

But certainly, there would be no argument that their history should have followed them and that it should have been made public to you. You should have been able to get that information. Obviously, had the hospitals been more involved in the background, it might have been prevented. I think it is an obvious statement, or an obvious answer to the question, but I would ask it anyway. I would obviously presume that if you had that information, you would not, either one of you, have used the physician.

It is not that kind of a situation that concerns me. I mean, no argument, let's hold these people up for public exposure. It is that fine line that concerns me. For example, if there was a physician

who had been sued for malpractice, it was least costly for the company involved to settle, never a trial, never going through the fine points and details of whether or not this individual, he or she, was actually at fault.

But just the fact that the suit had been settled then going on record, as a parent myself, whether it would be for my wife or for my children, I don't know at what point I would say, oh, well, after they have surpassed three of these or four of these or five of these or whatever, would I then no longer consider them.

It concerns me from the standpoint of very close personal family awareness of physicians, and knowing the kind of people they are, the capabilities they have, and what this particular individual has gone through. Because of the problems which are confronting them, there is a number of practices which this physician has decided no longer to do, and to those people who would have been the benefactor of his services, they will lose because this is an individual who would be a particular, very caring person.

What I want to make for certain that we don't do is to go so far that we begin to deprive the public of some people who should have been available to them and to not make it so difficult also that physicians decide that maybe they are no longer going to practice. It is that balance.

It is how much you know, how much a problem does exist before there begins to be a history, and that they put this person up for ridicule or bring them out publicly to allow the public to see what has happened. How much should we require that, as physicians go into new areas, there be a very thorough background check?

Do we leave that up to the States? Do we leave that up to the hospitals? Do we leave that up to the clinic in the case where an individual might be joining a clinic?

Those are the things that I hope we can answer, and when we can hopefully do some things that solve or help to solve the problems that you both have experienced, that we do that without being also overburdensome.

What suggestions or thoughts, given both of your experiences, could you give me to help us decide that?

Mrs. BENNETT. I think you have to give us the benefit of the doubt that we can be concerned consumers. If I had looked at that data bank and had seen a few malpractice suits, I don't think I would have been overly concerned. I would have been somewhat concerned and followed it up. I think I would have been very concerned if I had seen privileges being denied, suspension. That is what we are talking about.

We are not just talking about one or two malpractice suits or a settlement. I also would have looked at the amount of the settlement. In our particular cases, we are up to \$2.4 million. If I would have seen that amount of money, I would have known these are very serious situations.

I feel for you in your view of practitioners. My brother is a doctor. I saw him struggle through medical school. I know if he makes a mistake, it is not because he wanted to. He is a human being, and I think we understand that. Physicians make mistakes, but we are also saying that when they make one mistake, when

they make two mistakes, three, when are we going to stop and say enough is enough.

You are looking at one individual. I am looking at a lot of naive consumers. Yes; I feel that there might be times when we judge a person wrongly, a physician wrongly. But then on the other hand, if we don't stand up and start judging, we are going to have hundreds of consumers suffering under the bad doctors' hands.

Mr. BENNETT. I think part of the problem, at least in our situation, seeing the way that this has been handled when they came back for the second hearing in the State of New Hampshire is us being accused of being the reason that we were back having the second hearing. Had we not sent information to Texas, he would be gone right now, and they wouldn't have to be doing this again.

If we start policing and getting rid of the bad doctors, I haven't seen that happen yet. I agree with you. It is going to be very difficult determining where to draw the line, but the line is going to have to be drawn someplace, and there has to be a method to get rid of the doctors who are bad.

Mr. COMBEST. It doesn't require a response, but I thought if there was anything you wanted to say.

Mr. MILLER. The only thing I would like to say, as far as it impacted us, the doctor was in service in our community for only 8 weeks, and there were 13 separate counts, 13 grossly negligent incidents that were brought against him in New York.

I don't have the length of his service in New York, but he is a young doctor. This is not two or three cases settled for the sake of convenience, and the fact that, well, it was easier to settle this one. I realize those get entered. The thing that scares me is, I have also seen incidents where a doctor can hand in his license and, in effect, move to a new State and not have any record in the practitioner's data bank as he made a deal with the State examining board at that point.

Again, I would hope the consumer was there. I would hope the consumer had an active part in the medical examination and could then police for themselves the fact that this doctor is no longer practicing but may be a threat somewhere else. But if the State is content to let it drop there, have the doctor hand in his license, and, in effect, dump the doctor into another State, there is also going to be that contingency. The practitioners' data bank being open to the public addresses most of the problem, and the documented cases would be made available. But the doctors would always have that out, to go elsewhere.

Mr. COMBEST. Again, please understand I wasn't suggesting that this physician who had treated you was one who maybe just had one or two minor problems in the past. These are almost the extremes. I mean, we have falsified records. We have forgeries. All of these things are blatant, blatant problems that should be dealt with.

I think, as a general rule, the industry of physicians or of nurses or whomever, would like to see or would like to be able to police themselves. They recognize the kind of problems that these people create for the entire industry. What kind of reaction would you have if the physicians in the State of New Hampshire, the New Hampshire Medical Association, or Connecticut, whatever it would

have been, would have put out a sanction on this individual or would have put out information that there was a concern among their peers?

Would that have been a pretty significant warning to you if you knew that?

Mrs. MILLER. Yes; if we had known that. With Dr. Weber, as it stands now, he still holds a medical license in the State of New Jersey. To the best of my knowledge, he is not practicing medicine at this time. But this is a relatively young man who has had maybe a 10-, possibly a 12-year career who has already had his license revoked in two States. There has to be something done to protect the people in the State of New Jersey.

Mr. COMBEST. I concur. I completely agree with you. It is finding what to do. That is where we are all wanting to be, where we are all wanting to go.

Mr. Bennett, did you start to say something else?

Mr. BENNETT. Yes; if you call the State of Massachusetts Board of Registration right now to find out what they have on Dr. Dell, the doctor in our case, they will tell you that presently he has a license in good standing in the State of Massachusetts, and that is all the information you can find out.

Mr. COMBEST. That is where he is practicing now?

Mr. BENNETT. That is where he is practicing now in private clinics that he has built since he could not get hired into any hospitals.

Mr. COMBEST. In your case, had all of the plaques, all the degrees, or whatever that were hanging on his wall, had those ever been checked?

Mrs. BENNETT. No; because they were not medical education. This was all other education. They did check that he had a medical license, but that is as far as they went.

Mr. BENNETT. Until our suit was filed, they were not aware of that.

Mr. COMBEST. In your instance, this physician, the OB-GYN had purchased your former doctor's practice?

Mrs. MILLER. Correct.

Mr. MILLER. Correct. With very little input from the former doctor. He became incapacitated, and it was essentially a business decision.

Mr. COMBEST. Was it a single practice or a multiple?

Mrs. MILLER. It was a single practice.

Mr. MILLER. He has privileges at the hospital but wasn't on staff there.

Mr. COMBEST. Thank you, Mr. Chairman. Let me share the time.

Chairman WYDEN. I thank my colleague.

The gentleman from Nevada.

Mr. BILBRAY. I would like to say to the Bennetts, I know how you feel. I lost a son, too. When you lose a child, people can tell you they know how you feel, but they don't know how you feel. I say magnify it 10 times, and even then you don't feel the sorrow and the hurt that goes on.

I was wondering, and maybe Dr. White will address this, in the legal profession we have a publication that is not all inclusive certainly, not 100 percent accurate, which we call Martindale and Hubble which lists the attorneys, A, B, or C. When attorneys have

ethical problems or so forth, they refuse to allow them to be listed in the directory, or they give them no listing.

Has the medical profession ever done something like this? Has it ever been innovative that a person like the Bennetts or the Millers could go to a medical library or in this case a law library? I imagine most big public libraries have Martindale where they can open up a book and look up Dr. White, and find out he is licensed to practice in the whole United States, and he is rated by his peers in most cases as an A doctor or as a B doctor or C doctor, where if a doctor is questioned, and has been not allowed to practice in a certain State, that would be listed in his credentials so the Bennetts and Millers can go, and when say there are five doctors in the specialists in their area of their concern, they can look up that list and see if that is the situation. It would not necessarily list every case of malpractice or threatened malpractice but certainly would list the peer rating.

The way they do it, of course, in the legal profession, is you get a form, and it says they are requesting Mr. Wyden, and you would check off if you have problems, and you would seal that, and that was sent back confidentially. They would have a pretty good sphere to judge from. I was asked numerous times to rate my fellow attorneys. It is very difficult to get that A rating. He had to be in practice a number of years, and had to have a real high rating with his fellow members of the bar.

In some situations, it might be 500 attorneys practicing, and you might have only 5 or 6 A attorneys. You might find maybe another 50 B's. The normal average would be C's, but you also found quite a few that had no ratings at all because of their prior problems.

Has anything like that ever been considered, or is that done in the medical profession?

Dr. WHITE. Unfortunately, I am not an expert. I want to comment I have great empathy for all the other members of the panel. Most States' medical regulatory boards will at least submit to doctors who are in consideration for losing a license, the AMA and our specialty, like the American College of Radiology, do publish a directory which lists physicians, and also what schools they graduated from, and their specialties. But I am not aware of one that rates them by some peer evaluation and puts a rating on them.

Mr. BILBRAY. Do we have a group of physicians coming next? We have some testimony here.

Chairman WYDEN. We do have several physicians.

Mr. BILBRAY. I know the Millers and Bennetts think about something like that, a place where you could go for information. It certainly wouldn't be all inclusive. You certainly could go when you are looking for a doctor who would have treated your daughter or, in your case, your particular problem, that you could look into.

When I came from Nevada, of course, we had our longtime family physicians who we knew, and we knew most of the doctors. When we came here to Washington, we went through the same thing trying to find out who was a good doctor.

I called various people I knew, trying to find out who was an excellent doctor for certain procedures. I will tell you, when you come into a new area, it is tough, and doctors, as a whole, hate to down-rate their own, but if it was done privately and confidentially. I

would have loved to have been able to go to a manual over here at a library and looked up the ratings of the different doctors to see how they are considered.

I called home to my doctor; my wife had a problem. I called the gynecologist who is a good friend of the family, a good supporter of mine, and asked him to check out the particular doctor who we were looking at. He called back personally to the med school where she went, this lady, and also called a couple of his friends who were on the staff of Georgetown Hospital and asked about her.

But most people don't have the ability to do that. How many of them are going to get their local doctor, whom they have known for years, to make 20 phone calls across the country to find out if somebody is a good doctor. But if there was something there that you could open up and look at.

In the ratings done every year in Martindale, Mr. Wyden is probably an A attorney in Martindale, and he kept that rating for years until he became a Member of Congress, and he can't be rated anymore, because once we become inactive, we fall off the list. But that is important. That would be helpful to all of you, I believe, something like that. At least it would give you a fighting chance.

Chairman WYDEN. I thank my colleague. Do you have any additional questions?

Mr. BILBRAY. No; I am going to start publishing the book, though.

Chairman WYDEN. The gentleman from Massachusetts.

Mr. MEEHAN. Thank you, Mr. Chairman. I would like to ask the Bennetts, the glowing recommendations from Tufts, were you able to see those?

Mrs. BENNETT. Yes.

Mr. MEEHAN. Do you actually have copies?

Mrs. BENNETT. We have two copies of two different physicians who wrote very favorable recommendations to Wentworth-Douglass Hospital.

Mr. MEEHAN. To what extent, if any, have those physicians been held accountable for those recommendations?

Mrs. BENNETT. I don't believe at all.

Mr. MEEHAN. That concerns me, and if you could get a couple of copies to my staff, that would be appreciated. I spent 4 years regulating securities in Massachusetts, and we have a computer system whereby we keep track of a person who is a broker-dealer selling securities anywhere in the country, and we keep track of it.

Anytime someone would apply in Massachusetts as a broker-dealer to regulate securities, we would check it in the computer system, and we would know of any disciplinary action anywhere in the country. Oftentimes, people get a speeding ticket in one State, and it comes up in the computer in another State, and it is interesting that we don't seem to have the ability to keep track of doctors and actions that they have had.

But if you could give me some additional information on that, I am going to have a staff member talk to you afterward, and I would like to pursue that with Massachusetts officials.

Thank you, Mr. Chairman.

Chairman WYDEN. Thank you. I thank my colleague.

Let me see if I can get out what seems to me to be the heart of the concern for you all, the Bennetts and the Millers. As I understand, what you all have told us is that you think the person who is in the best position to advocate for the patient is you and your family, but the people who have the information won't give it to you.

Essentially, these medical authorities won't give it to you so that, in effect, you are denied any real choice and any opportunity to do what you want to do most, which is make your own informed judgment. Is that correct?

Mrs. MILLER. Exactly.

Mr. BENNETT. That is correct.

Chairman WYDEN. All right. Mrs. Bennett, as I understand what you told my colleague, Mr. Combest, and that was a very thoughtful answer, what you are most interested in is the kind of pattern that emerges from the information about a provider.

You would recognize that a preliminary investigation about a provider or a charge on the part of some plaintiff isn't really necessarily determinative that that provider is a bad physician, but what you are most interested in is knowing about multiple cases and very serious kinds of infractions so you could sense that there would be a pattern that would be relevant for you all.

Is that right?

Mrs. BENNETT. Exactly. I think what I would look at is the number of cases and the number of years. If I saw one in 1960 and then another one in 1982, no; I wouldn't be overly concerned. I would be somewhat concerned, check into it, and I think I would even have the right to ask the doctor about the situation.

I also, though, have been stung. I know now that doctors do lie to you when you ask questions, so I would maybe go a little further, but I wouldn't be overly concerned.

Chairman WYDEN. Given the fact that this matter of a pattern of information or serious infractions is what you are most interested in, what would be your response to some of those who have been fighting the efforts to open up the data bank because you would be confused, and that you would not be able to understand this kind of information, and that, as a result of your being so confused, it should be denied to you.

If anything, it strikes me that you are in a kind of confused state when you don't get information. I have always been a little bewildered at the logic behind this argument, but what would you say, Mrs. Miller, to the idea that patients and families like yourselves ought to be denied this information because somehow you wouldn't understand it.

Mrs. MILLER. There may be people out there who wouldn't understand it. We are not all ignorant. If I don't understand something, I could go to a doctor and ask, please explain this to me, and where do I go from here. Right now, we have very few doctors who will testify against one another. We were fortunate.

We had three doctors testify on our behalf against Dr. Weber. I may not understand everything that is in the national data bank but, like Mrs. Bennett says, let us make our own decision. Going to see a doctor is greatly a matter of subjectivity. You have to feel comfortable with this person. He may be a fabulous doctor, and if

you don't feel comfortable with him, you are not going to want to go to him.

Chairman WYDEN. You are just being too logical. You can't let all this logic break out over Federal policy on a regular basis. I think your point of knowing when to ask is absolutely one of the keys here. In fact, one of the things that I am going to be pursuing as part of my effort to open up the national practitioner data bank is the idea that an explanatory booklet would be issued by the Federal Government so that not only would people be able to have access to this kind of pattern of information that Mrs. Bennett has been describing, but also that there could be a booklet in language resembling English that would be given to patients and the families so they could get explanatory material about what the information in the data bank meant.

A couple of other questions for you. I am curious about what you think of hospitals and State agencies cutting deals with these physicians to just let this kind of information either go or slide to the side and somehow not get out, because that seems to have been relevant to both of your situations. What is your reaction?

Mrs. BENNETT. Totally frustrating. I think maybe that has been the most frustrating. We understand we have a serious situation—a doctor, a bad doctor. I mean, we know he is a bad doctor. We can't do anything about it. We can't make him a good doctor at this point, but we can make sure that he doesn't hurt anybody, and that is where we feel there is nothing being done.

We have tried writing letters. When you said getting information from the data bank, we are not getting that choice, but we have also been trusting people to monitor these doctors, and they are not doing a good job. We, in our situation, wrote complaints and nothing was done, and only through legal services could we get information from the hospital. All that information was blocked from us.

I guess our emotion is total frustration, total dismay that many times we are blamed. Like I said, the prosecutors said, if you hadn't gone ahead and sent letters to Texas, he would be gone. It is like, why are these agencies all working within their own State? Why aren't we looking at it as a national problem? Why is it that a doctor can go from one State to another and start the whole horrendous episodes again?

Chairman WYDEN. Well, there is a little frustration on this side of the dais, too, Mrs. Bennett, because I have the data bank information sheets on the physicians that you all have been discussing, and the fact that I can't give them to you or make them available to other consumers is pretty frustrating up on this side of the dais, too. I appreciate your answer.

Mrs. Miller, did you want to add anything?

Mrs. MILLER. We are very upset to find out that the hospital in our community knew about Dr. Weber's former charges, because we live in such a small town. We know a good number of the doctors personally. My family, most of my family, at one time or another has in one capacity or another worked in this hospital, and they allowed him to have privileges there.

We are told afterward that there is no liability on the hospital's part because he wasn't technically employed by them. He had

privileges in the hospital. He was not on their staff. So, they allowed him to work. Yet, we can't do anything to them. They just wash their hands of it and say, well, we are sorry this happened.

Chairman WYDEN. So, as I understand your situation, Mrs. Miller, the problem that you described to the subcommittee was, in effect, an outpatient surgery, was it not?

Mrs. MILLER. Correct. That was done in his private office.

Chairman WYDEN. This subcommittee has always been concerned about the lack of oversight and peer review of a lot of these outpatient surgeries, and we are hopeful to get some oversight and some accountability for that fast-growing area in health care as well as part of health reform.

A question for you, Ms. Perez, if I might. I think anyone listening to your situation being told as a patient you can't get access to the person who is going to make the decision whether you get the service, anyone who heard that would be angry about health care in America.

I am curious when they approached you about joining this plan, did they lead you to believe that people would give you access to that kind of information?

Ms. PEREZ. They didn't really tell you much. What they do is they try to tell you that it is better than what the Government will give you. When you go to an HMO, they tell you all the benefits, like when you are in a regular Medicaid Program and you are over 21, you don't have as many dental benefits or you have to pay, and when you go on their HMO, they pay for things that are not covered with the regular Medicaid.

But they don't tell you all the problems that happen. For example, if you get out of work at 5 o'clock, where do you go?

Chairman WYDEN. I am sure they didn't volunteer when they were selling you the policy that, if you called, they would tell you it was none of your business. But I gather that you thought the service would be covered, and you were led to believe that this particular service would be covered, and it would be something available to your family; is that correct?

Ms. PEREZ. Right.

Chairman WYDEN. The other question that I had for you, Mrs. Perez, and the Millers, and the Bennetts, is as part of health reform, there is a great deal of discussion now about exactly what the array of choices ought to be for consumers, and how do you balance that with everyone's desire to hold down costs?

Would you all be satisfied with health care reform legislation if you were given a once-a-year choice between various kinds of health insurance, programs like health maintenance organizations, or do you want more information than that, such as malpractice and quality information on individuals who are part of these plans?

Mrs. BENNETT.

Mrs. BENNETT. I think I would like the information, as much information as I possibly could get. Again, I would be willing to gather that information if they would give that information to me.

Chairman WYDEN. Mrs. Miller.

Mrs. MILLER. I agree 100 percent with Avis, and I think that it has become apparent to me that you cannot take a doctor's word as gospel the way a lot of us have been brought up to believe. You

have to learn to ask questions, and this is something that only you can do. When you want to find out about a physician, it is so important that the information is accessible to us so that we can make these choices.

Chairman WYDEN. Ms. Perez, what are your thoughts in terms of health reform? Is it enough to you that you get a once-a-year choice about your plan or do you want to know about what it is you are getting?

Ms. PEREZ. I think I would rather know about what I am getting. In my case, I also lost a child. The doctor did determine I was 4 months pregnant, and they sent me home, and they told me there was nothing at all wrong with me, and I ended up losing the baby while I was walking across the street from the hospital, because I did not know for sure if I was pregnant or not.

By then, before the blood tests were even done on me, they told me I wasn't pregnant, and just sent me home. I lost my job, also, because I didn't think to find out a little bit more about the HMO that I was going into. When you do call them, they don't give you any information. So, I think information is more important.

Chairman WYDEN. Dr. White, you mentioned one of the models that this subcommittee has been looking at, the point of service health maintenance organization, where, in effect, you can get outside of the organization by paying a little bit more. The good ones find that patients usually don't feel that they have to get out of the organization, because that point of service feature tends to keep the organization more on its toes so they give consumers good care while holding the prices down.

Are there any other models that you could commend to the subcommittee that would allow for the balance between good quality, cost containment, and choice?

Dr. WHITE. There really aren't any others that I am aware of. I think the point of service option is an excellent one for a patient with a rare disorder, and again, that is 10 percent of us. I am horrified by the examples I have heard this morning. I still have a great deal of faith in the medical profession.

I think there are many doctors who are practicing excellent medicine in the hospitals where they are credentialed where the HMO's do look carefully into those records. Unfortunately, that doesn't appear to be the case from this morning and from what we have heard. I still have a great faith in our profession.

I think for the patient, and there are 25 million Americans who have a rare disorder, this point of service option is an excellent one because that would allow them then to seek out an area of excellence where there are a group of doctors and nurses seeing patients with special situations.

Now, if the point of service is such, though, that they are ending up paying half the bill, and if they are paying the large bills that some of our medical centers generate, then that really isn't much choice for those patients. So, I think if we go to that option, we have to make it a small financial increase over the standard 90 percent of patients who would have access to the regular amounts paid to an HMO or other health maintenance organization, but I think the point of service is the best option.

Chairman WYDEN. Let me tell you two things before you all are excused. First, I think the accounts that you have given us represent what is on the mind of millions of Americans as Congress begins to get into this national health reform debate.

I am absolutely convinced citizens of our country do not want to delegate the right to choose the medical provider that is best for them to some unknown, unseen kind of health care organization, and I think what you all have done is put in very clear terms what happens when people don't have sufficient information to choose, and it has been exceptionally helpful.

I also want to leave you with a judgment about what Dr. White has said and something I feel very strongly about. The vast majority of physicians and medical providers in this country are honest, decent, and caring. There is absolutely no question about it. One of the reasons we are going forward with this effort to open up the data bank is that I think it does a disservice to the majority of doctors who work so hard and care so much for the Government to keep covering up for that minority of their peers, who are causing the kinds of problems that you all have described, as they leap from State to State constantly circumventing appropriate medical authorities.

You have done a great service in coming today. I think you speak for millions of our citizens as you call for the right of access to information in the data bank, the right to choose medical providers in a responsible way, and we thank you for the service that you performed. I know we are going to be talking to you in the days ahead. We will excuse you at this time.

Chairman WYDEN. Our next panel is Martin Schneider, publisher of Health Pages, New York, New York; Dr. Edward Hannan, Ph.D., consultant to the New York State Health Department, Albany, New York; Mr. Ernie Sessa, executive director, Pennsylvania Health Care Cost Containment Council, Harrisburg, Pennsylvania; and William Mohlenbrock, M.D., medical director, Iameter, Inc., San Mateo, California.

Let us ask our guests if they could quietly take their seats, and we will be able to continue what is sure to be a lengthy hearing.

Mr. Schneider, Dr. Hannan, Dr. Mohlenbrock, and Mr. Sessa, we welcome all of you. It is the practice of this subcommittee to swear all the witnesses who come before the subcommittee. Do any of you have any objection to being sworn as a witness?

Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. Gentlemen, we are going to put your prepared statements into the record in their entirety. We have said on a number of occasions that we know that everyone is almost congenitally compelled to read their statements when they come to the Congress, but we will put your statement in the record. If you could just take 5 minutes or so to summarize your principal concerns and talk to us, that would be very helpful.

Let's begin with you, Mr. Schneider. Welcome.

TESTIMONY OF MARTIN SCHNEIDER, PUBLISHER, HEALTH
PAGES

Mr. SCHNEIDER. Thank you. Good morning and thank you for the opportunity to testify before this committee. My name is Martin Schneider, and I am the publisher of Health Pages, a magazine that provides detailed, provider-specific information to help consumers make informed health care decisions.

Let me give you some examples of the type of information. A recent issue in Wisconsin informed readers that one local doctor charges \$2,500 for maternity services while another charges only \$1,250 for those same services.

One area hospital has a caesarean section rate of 21 percent while another has a rate of only 10 percent. The purpose of disseminating this information is to change health care patients into health care consumers and to provide incentives for health care providers to improve the quality of their care.

I started a health care management firm, 7 years ago, which set up and operated medical facilities including x-ray centers, laboratories, and home care companies. My previous business training did not prepare me for the lack of competition I found in my corner of the health care system.

As long as our services were adequate, patients and referring physicians never asked us the most important questions like what was the quality of the service we were selling and at what price were we selling it? No one asked about the quality or age of the equipment, the training of the technicians, or the backgrounds and experience of the physicians who worked in the facilities.

Because there was no flow of basic information to our consumers, there was no incentive for us to offer the highest quality services at the lowest price. This experience demonstrated to me that the free flow of information was crucial to any competitive system and, in the case of health care, would dramatically improve both the quality and efficiency of the U.S. health care system.

The health care information is in its infancy, and it has regrettably been controlled and stymied by the providers themselves. Knowledge is power and the providers well understand this fact. When people pay for health care or any service, they have a right to know what they are getting.

The seller of the service should no longer be dictating the terms of this transaction. For patients to become consumers, they must have access to information which highlights the price and quality differences between physicians, between hospitals, and between health care plans.

While individuals have traditionally understood that there are differences in such characteristics, like bedside manner, few understand that there are significant differences in clinical approach, medical outcomes, and cost of service. All providers' services and prices are not alike. Higher prices do not mean higher quality.

Once consumers accept that there are differences in medical practice and approach, they will want to know more about the physicians and hospitals they use. For managed care plans, consumers will want to know about each plan's performance, how doctors are

selected, how the plan assures doctors' performance, and how well the plan meets its enrollees' needs.

As this type of information becomes more widely available through publications like Health Pages, consumers will in turn demand even more comprehensive information on their health care providers. Unfortunately, comparative information about providers or plans is not publicly available or simply not available at all.

Today, there are only 37 States that mandate the collection of health care data and, out of these, only 3 States, Wisconsin, Arizona, and North Carolina, allow for the release of physician specific data.

Let me describe an example of how information properly gathered and widely distributed can immediately improve the quality of care, decrease health care costs, and turn patients into consumers.

A caesarean section is the most common operation in the United States and currently occurs in 24 percent, or nearly one out of every four deliveries. This past April, the Centers for Disease Control and Prevention reported that the medically appropriate rate should be 15 percent rather than the 24 percent that exists today. If this rate was achieved nationally, there would be 350,000 fewer caesareans a year and an annual savings of over \$1 billion. Reducing the number of caesareans sounds like a worthwhile goal to improve the quality of care and save billions of dollars at the same time.

Let me suggest a way that collecting and disseminating consumer information can accomplish this goal. Various States have mandated that hospital C-section rates be made available to the public. This information is not terribly useful because people generally do not choose a hospital for maternity services. They choose a doctor. A more appropriate set of data would be caesarean section rates for individual doctors.

In the Wisconsin issue of Health Pages, individual physical C-section rates were published for the first time ever in this country. I have been told by many doctors and several hospital medical directors, that if obstetricians know that C-section rates will be published on a regular basis, many unnecessary C-sections will no longer be performed.

Maternity services are an extremely common and highly visible medical service. This committee may want to consider sponsoring legislation that would mandate the public availability of physician specific C-section rates just as Representative Wyden successfully sponsored legislation that required that infertility clinics release their success rates. The results of such C-section legislation would demonstrate differences between providers, engage consumers, establish physician accountability, and lower health care costs.

Critics claim that Americans are not smart enough to make their own decisions about health care. These critics underestimate the American public and the power of information. Protecting people from information is not the Democratic American way. Arming consumers with information and helping them to protect themselves is the American way, and is critical to a more efficient health care delivery system.

Thank you for the opportunity to testify before you this morning, and I look forward to answering any questions or providing any additional information you may need.

[Mr. Schneider's statement, with attachment, may be found in the appendix.]

Chairman WYDEN. Mr. Schneider, thank you very much for excellent testimony. We will have some questions, I know, in a moment.

Dr. Hannan, welcome.

TESTIMONY OF EDWARD HANNAN, PH.D., CONSULTANT, THE NEW YORK STATE HEALTH DEPARTMENT

Dr. HANNAN. Thank you very much for the opportunity to testify this morning. My name is Edward Hannan. I am professor of health policy and professor of biostatistics at State University of New York at Albany, and I am a consultant to the New York State Health Department. I have been the director of the research and analysis of New York's innovative cardiac surgery program since its inception in late 1988.

Prior to that time, New York State had convened a Cardiac Advisory Committee for approximately two decades and the purpose of the advisory committee was to help the New York State Health Department make decisions on the quality of cardiac surgery and angioplasty, to monitor the appropriateness of surgery, and to investigate issues related to the control of cardiovascular disease.

For those two decades, information that was available to the committee and to the State Health Department consisted primarily of aggregate information provided to the Department from each hospital which contained the number of procedures performed, the number of deaths, and the number of complications et cetera.

It came to the attention of the Health Department and the Cardiac Advisory Committee during that period of time that there were huge differences in mortality rates and complication rates. These differences were attributed by the hospitals to differences in the mix of patients who received surgery at the hospitals.

Finally, after 15 or 20 years of this, the Health Department and the Cardiac Advisory Committee decided that the issue needed to be investigated in more detail and decided to develop a surgery system whereby detailed information on each case was provided to the committee and to the Health Department. This information would contain risk factors of all the patients, demographic information, and discharge information concerning whether the patient lived or died, and various complications surrounding the cardiac surgery.

The major purpose of this registry, which was first initiated on January 1, 1989, were, first of all, to provide information to hospitals in the State that would aid them in assessing and improving their quality of care; second, to assist the New York State Health Department in assuring quality of care among the hospitals prioritizing site visits and determining which hospitals should receive further scrutiny; and third, to provide information for consumers that would enable them to select providers of cardiac surgery.

The main aspect of cardiac surgery which has been concentrated on in this period, because it comprises more than 75 percent of all cardiac surgery, has been coronary artery bypass surgery.

The Department of Health has used information on coronary artery bypass surgery to develop a statistical model that would predict the probability of a patient dying in the hospital as a function of the risk factors of that patient and then applying that statistical model to the assessment of various providers of cardiac surgery, both hospitals and surgeons.

Data from the system provides the foundation upon which many quality improvement activities are based. Hospitals, at which bypass surgery is performed, receive data on a regular basis from the Health Department in which their actual mortality rates and their risk adjusted mortality rates are reported to the hospitals, and examinations of this information have led to marked improvements in the rates of mortality at the hospitals in New York State.

Furthermore, the department provides each hospital with a computed diskette which contains a list of preoperative risk factors for bypass surgery which are significantly related to inpatient mortality, and the users are able to use that diskette for any given patient to predict that patient's probability of dying in hospital. So, one of the purposes for which this is used is to assess the appropriateness of surgery for various patients.

Also guided by the Cardiac Advisory Committee, the New York State Department of Health uses these data to assess specific quality improvement interventions in hospitals with the highest risk adjusted mortality rates. These interventions have included site visits, comprehensive consultations, and placing some programs on a period of probation until recommended changes are instituted to improve the quality of care.

With regard to consumer information for bypass surgery, the health department has publicly released information by a provider on the volumes of cases performed, the actual mortality rates, and the risk adjusted mortality rates as well as identifying which hospitals have significantly higher or lower mortality rates than expected. The hospital-specific information has been released since 1990 on an annual basis and the surgeon-specific results have been released since 1991.

There was a reference earlier about the surgeon-specific release. The history on that surgeon-specific release is that in 1991 the New York State Health Department decided not to release the surgeon-specific information because so little information was available at that time in terms of the volumes performed by each of the surgeons. The Department of Health was sued by Newsday and forced to release the information under the Freedom of Information Act.

Since 1991, the New York State Health Department has proactively released this information on a 3-year basis so that the volumes for each surgeon are large enough to be meaningful in terms of predicting future performance. The Department of Health are now releasing information for surgeons on an aggregate 3-year basis and releasing information for hospitals both on a 1- and 3-year basis.

The particular information that is released is part of the written testimony here, and I will be pleased to answer any questions

about this in more detail, but essentially what you will see for each hospital and each surgeon in a hospital, are the number of patients, the actual mortality rate, the expected mortality rate, which is a function of how difficult the caseload is for the hospital and the surgeon, and the risk adjusted rate which essentially irons out differences in severity of illness and rates hospitals and surgeons as if they had a case mix that was identical to one another.

We believe that this quality improvement program, based on the collection and dissemination of risk-adjusted mortality data, has played a significant role in improving the performance of this procedure over the past 3 years in New York State.

As evidence of that fact, the mortality rate, which was initially 3.52 percent in 1989, has decreased to 3.14 in 1990, to 3.08 percent in 1991, and to 2.72 percent in 1992. Thus, the rate has decreased steadily over the 4-year period of time.

The total decrease over this period is 23 percent. This decrease has been achieved despite the fact that the average severity of illness of patients undergoing surgery in the State has decreased over that 4-year period. The actual decrease in risk-adjusted mortality rates over the 3 years is a decrease of 36 percent.

In 1991, the New York State Department of Health has instituted a similar program in coronary angioplasty, and efforts have already begun to collect data related to the care of trauma patients and neonatal intensive care patients in preparation for assessment of provider outcomes.

Thank you.

[Dr. Hannan's statement, with attachment, may be found in the appendix.]

Chairman WYDEN. Doctor, thank you. That was very helpful testimony.

That reduction figure you gave for 1992, what was that again?

Dr. HANNAN. Between 1989 and 1992 the reduction is 23 percent in crude mortality rates, not taking into account the risk adjustment. If you look at the fact that the severity of the patients has increased over time, probably due to the fact that angioplasty has taken patients from the lower end risk of bypass surgery, it has gone down by 36 percent in just 3 years.

Chairman WYDEN. We will have some questions in a moment. I was not sure I was hearing right. We know that access to information can make a difference but that is really extraordinary.

Let's go now to Dr. Mohlenbrock. I am compelled to say we will have to keep you all to 5 minutes. We will make your prepared statements a part of the record.

TESTIMONY OF WILLIAM MOHLENBROCK, M.D., CO-FOUNDER AND MEDICAL DIRECTOR, IAMETER, INC.

Dr. MOHLENBROCK. Thank you, Mr. Chairman.

Let me introduce myself by saying I am a practicing orthopedic surgeon, though I am spending more time in the office and less in the operating room these days because of my commitment to the efforts that you are talking about.

my partner and I started an organization called IAMETER 10 years ago. We are two physicians who are convinced that good doc-

tors given good data will quickly modify their behavior toward higher levels of both quality and efficiency.

We are dedicated to assisting in physician behavior modification by giving physicians better tools and techniques so they can identify the variations in the way they practice on an internal basis from which they can begin to modify their behavior and start to improve.

There are two issues we are really dealing with here, at least at this committee level. First, what is medically meaningful data that needs to be gotten out to the public for those of us who are consumers and providers, and second, the issue of clinical reliability, as we have just heard from the State of New York.

We, as an organization, are absolutely dedicated to giving more information, both to physicians and to consumers. In our process, we take information from a hospital, and we severity adjust the data that has been collected in the medical record so that we can show each physician the economic and the quality ramifications of their ordering pen. The physician's ordering pen is the most expensive medical device in the hospital because through that ordering pen we physicians control how many tests and treatments are consumed.

Chairman WYDEN. It looks like a Bic but it costs quite a bit more. Is that what you are saying?

Dr. MOHLENBROCK. Exactly, to say the least. We take this information to physicians down to the medical and surgical service levels, the orthopods, the cardiologists, the orthopedic surgeons, the cardiac surgeons, and we effect physician behavior modification by facilitating open discussions which affect practice changes.

We have been at this now for 10 years, using a continuous quality improvement process. We take the clinical, patient-level information to the doctors so that they can talk among themselves and reason together as to how they can reduce variation and improve their outcomes.

The definition of "quality" has been well defined. Actually, the Congressional Office of Technology Assessment and the JCAHO have now decided that the definition of "quality" is "the degree to which the process of care increases the probability of desired patient outcomes." In other words, those processes of care, if we do them all correctly, should affect better outcomes.

Certainly, we have seen evidence of that. In fact, we just completed a year's study in Cincinnati where all the hospitals used our severity adjustment and CQI techniques. The results were astounding. Not only did we not have degrading quality, the quality was enhanced in terms of reductions in variation, performance in the clinical indicators of quality that we examine, such as C-section rates, morbidity, and mortality rates. We were also able to show that the hospitals and doctors saved more than \$150 million in the first year simply by giving good doctors good clinical data to modify their behavior as appropriate.

As a private practitioner, I can tell you I have been very frustrated over the last 20 years in practice as a consumer trying to get information on physicians such as we have just heard about from New Jersey or Massachusetts. Where do you go to get such information? We get these glowing letters about every doctor. I under-

stand what is behind some of those letters. The physicians writing those are very concerned about the issue of legality, that is, is this going to be a restraint of trade? If I don't write a good letter, and he doesn't get on the staff, will I be brought into a restraint of trade issue? Let's not miss that. Tort reform will be very helpful to that issue. So, there are lots of things that we need to address to get access to this vital information.

The national practitioner data bank is an excellent start. The good physicians and hospitals agree with you absolutely. We have excellent physicians in this country. We have to protect the consumer and those good physicians who want to continue to improve. That is the kind of physician level information we need to assess a physician's competency.

Other helpful data would include the number of procedures that a physician performs. That is very important as well. Thousands of patients have asked me, Doctor, how many have you done? These are the kind of structural things we need to know about a physician.

With regard to the clinical information and the report card idea, that is an excellent idea, but you have to understand that those clinical bits of data are going to have to be clinically reliable. We simply can't be saying a physician's infection rate is 1 percent versus this one is 3 percent. These numbers are so low as to not be statistically reliable. We don't want to overstep the bounds of the data. There is a new area of data acquisition, and we must not begin chastising excellent hospitals and physicians with information that is not clinically reliable.

In summary, we need more information. Consumers in this country are well-educated as to what they and their family need for health care. We need to give them more information, not less. Let me assure you, we have phenomenal physicians and hospitals in this country. You give them better information, and all the indications are that they will continue to use that information in an improved way to continue to improve the quality and efficiency of their care. Thank you.

[Dr. Mohlenbrock's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Doctor, thank you. It is very helpful. I know we will have some questions in a moment.

Chairman WYDEN. Mr. Sessa, welcome.

TESTIMONY OF ERNEST J. SESSA, EXECUTIVE DIRECTOR, PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL

Mr. SESSA. Good morning. Thank you very much for having me to testify this morning. I will be brief. I think I can expound on what the previous speakers have been talking about.

In Pennsylvania in 1986 there is a law. The law says hospitals and doctors must,—it is mandated—provide information to the public. We believe Pennsylvania people are smart enough to understand the information that we provide them.

Obviously, the medical community and the hospital community of Pennsylvania would rather us just provide the information to the hospitals and the physicians. We don't think that will work. In

order to have an informed purchasing consumer, they must have information that is usable, understandable, accurate, and reliable. We have been doing that since 1989.

Our first report was on hospital effectiveness, how well did the hospital perform based on an expected standard. We used a system that we put into place in every hospital in the State of Pennsylvania so it would be consistent.

Every hospital had the same system to look at the conditions that we were reporting on. We reported on 60 different conditions in Pennsylvania from adult pneumonia to coronary artery bypass surgery. We also look at variations on the treatment. It is one thing to be in the hospital and to get good care, efficient care, quality care, and care that is affordable. It is another thing to be in there at all if you don't have to be. Is it appropriate to have the care? So, we look at small area analysis and make that available to the public to see if there are wide variations in the number of hysterectomies and other conditions from one neighborhood to another.

We have recently published a report, a consumer guide for coronary artery bypass surgery, in which we not only reported the hospitals' severity-adjusted outcomes for coronary bypass surgery, but also the physician. We published the report on the expected number of deaths based on the number of actual deaths, and then we look at the actual charge for the services, and we make them available to the public.

The information is being used by the public as evidenced by the fact that we released about 50,000 overall reports in the last couple of years to people who have written in or called in and asked for the information, and they use it.

We are trying to promote a competitive marketplace in Pennsylvania and in order to do that you must have information. You have to have it for managed care, managed competition. This information is not easy to get. You have to struggle. You have to make sure that it is information that the hospitals and physicians will agree is reliable and useful information.

We have been able to do that over the past several years. We have established a good relationship with the medical community. We have a council that is independent, an agency that is run by business representatives and labor representatives. We have consumers. The hospitals are represented, as well as the insurance companies, physicians, and State government. All are in this together to provide this information to the community.

We see that the hospitals are also using that information internally, not only to sell their product, but to improve the way they do business. Before this information was made public, hospitals did not know how well they compared to another hospital. They didn't know how many procedures they were doing compared to another hospital and what their performance was. With this information, hospitals now have the ability to see how they stack up. So, there has been total quality management improvement in all the hospitals by using this internal system that we mandated that they put into their hospitals.

We think the quality of health care in Pennsylvania continually improves every year. We have seen evidence of that because hospi-

tals have shared that with us. Consumers are also sharing the fact that they have gotten information from the council that has really helped them in purchasing health care from a more efficient, reliable provider. We think it is important. We will continue to do this. Hopefully, we will get additional information out on psychiatric care, rehabilitation, infections readmissions, out-patient treatment, additional physician reports, and comparative reports on reimbursement rates to doctors and hospitals. All that kind of information we think, is helpful to the consuming public.

Thank you.

[Mr. Sessa's statement may be found in the appendix.]

Chairman WYDEN. Very helpful. I will have questions in a moment.

First, I recognize my friend from Nevada.

Mr. BILBRAY. Mr. Schneider, you mentioned your publication. Is that published in every State or is it limited to certain States, and how often is it published, and how in-depth do you go in mentioning these particular physicians or types of practice?

Mr. SCHNEIDER. Magazine copies are available here. It is currently available in Wisconsin and will be available in St. Louis this September. It is only 1 year old. We need a little time to get to all the States but that is our goal. The magazine comes out on a quarterly basis and is available to the public on news stands, by subscriptions, et cetera.

As far as the level of information, we try to present it on all different levels that people access information, whether it is on a health plan level, hospital level, or the doctor's level. Wherever there is information available, whether that is gathered through—as you talked about earlier—the idea of surveying peers. We expect to survey physicians about other physicians, survey nurses about physicians, and finally survey the public about physicians.

We can see how that spectrum goes across in trying to deal with the issue of popularity versus quality and see how these intermingle. But we feel that the most important level of information to provide is the level on which people make those crucial decisions as we learned about this morning, which is at the physician's level.

So, consequently, we try to print doctors' names, their backgrounds, where they went to school, whether they are board certified. We publish service issues such as whether credit is available, whether evening hours are offered, whether blood drawing is available in their office, et cetera, besides things like prices.

Mr. BILBRAY. The previous witnesses, the Bennetts and Millers, would they be able to look in your publication and know, when they are going to a neurologist, and Dr. Dell, I think that was his name, was on the list, would they be able to, by looking in your publication, go beyond whether they took credit cards, whether they had disciplinary procedures filed against them, or had a suspended practice in different States? Would that be in your publication or not?

Mr. SCHNEIDER. We have not done that in the past. We expect to do it in the future. We currently do not print information about physicians who are having problems with the State or other disciplinary boards.

There is only one publication that I am aware of that gathers that information and makes it available to people. That is Dr. Sidney Wolfe's public citizen group. In our publication, you can see whether or not the doctor did go to the schools he said he did because we do check the integrity of what the physician says, not only to us but to State boards and the national specialized agencies.

Mr. BILBRAY. So, if he said he went to Yale and he actually went to the University of Guadalajara, you would get in touch with Yale and publish that?

Mr. SCHNEIDER. Yes.

Mr. BILBRAY. Dr. Hannan went into great detail about particular hospitals and the ratings between hospitals. In your testimony, you said you thought that kind of knowledge, even though it was beneficial hospital to hospital, was not good for the patient because the patients really did not have much opportunity. They pick Dr. Smith and Dr. Smith practices at a hospital that has a higher than normal mortality rate for certain types of procedures. That doesn't do much good for the patient because what he really needs to know is what is that particular doctor's percentage, correct?

Mr. SCHNEIDER. Yes.

Mr. BILBRAY. What I think Mr. Schneider is saying is that is great information, but to the individual patient, it doesn't really mean very much.

Mr. SCHNEIDER. On the flip side of that, to the individual physician, it might be serving a real disservice. You are going to get an average mortality or an average caesarean section rate. So, it would be an average. Some doctors are above or below that. If you were to go to a physician who was doing a very good job, you might change your mind based on that hospital information.

Mr. BILBRAY. I would think so.

Mr. SESSA. We provide both hospital information and physician information in the same report so that you can see how many processes were done in the hospital and how many the physician did as well as the physician group, so that you can see whether or not the hospital is doing a lot, and whether or not the physician is doing a lot, and whether or not their practice is doing a lot.

We rate them based on severity adjusted information. In other words how sick were the patients, how many vessels did they do, whether or not they had complications of congestive heart failure. When you even the playing field, you can see how well each physician did and how well each hospital did in treating that patient for that particular service and try to make that information available and understandable.

Mr. BILBRAY. Is that sort of information available at medical libraries, general libraries, or do they have to call your office to get that information?

Mr. SESSA. We make it available in the libraries, the local chamber of commerce offices, through the various union offices, and through the State legislature; any way we can get that information out, and it is free to the public.

Mr. BILBRAY. Does anybody else have a comment?

Dr. HANNAN. We also provide the same information, both for physicians and hospitals. There is a news conference that signals the release of the report. It is also available to the public by calling

in the health department. It is both physician and hospital related and also, as with the case of Pennsylvania, it risk adjusts and looks at confidence intervals so that you are not saying that someone has done a higher rate when it is not significantly higher. It will tell you, in effect, whether the rate is something to be wary of because it is significantly different than what is expected based on the patient mix.

Dr. MOHLENBROCK. If I could make a comment, we are talking about C-section rates and coronary artery bypass. These are the high volume procedures where we do have enough volume, and where we can get intervals that give us good confidence.

One of the concerns I expressed a minute ago is in these areas where we don't have large volumes of either numbers of patients or cases. All I am saying is that we have to be cautious and try not to read more into the data than is truly there. That is what I meant by the confidence interval or the clinical appropriateness.

So, we need to caution ourselves that we don't try to do more than the data will really tell us we should do. That is one point.

The other point is, when we are looking at hospital issues, even though I do an operation in a hospital, I am with that patient far less time than the hospital nurses or ICU staff. Often we have system problems, not just physician problems. So, it may come out as a physician number, but it could be a system problem. That is why we have to be a little bit cautious with the data. That is my only warning.

Chairman WYDEN. I thank my colleague. It seems to me that access information comparing one health care provider to another is going to have to be the life blood of any functioning competitive marketplace. I don't see how you will be able to have this competitive marketplace if you cannot get comparative information, and yet, as Mr. Schneider talked about in starting the panel, there are barriers virtually everywhere in getting access to this information.

I am curious as to what you can tell us as to how these barriers came to be erected. How is it that across this country there are these very high walls that consumers have to try to scale to get this kind of information? Mr. Schneider?

Mr. SCHNEIDER. I was not at every meeting in each State legislative office, but I would assume the pattern repeated itself. The people who had the power and influence were drawing the laws about what data should be collected and, most importantly, to whom that data should be released.

Clearly, the pattern is that the public should not have access to that information. Even in the two States represented on the panel today, Pennsylvania and New York, I think both those States are doing as good a job as any other States with the information, but neither allow the public to ask for information. Health Pages Magazine tried to access physician-specific, C-section rates in both of those States. They both have processes that you have to go through, meaning State subcommittees where you have to bring a presentation, and in front of a group of people composed of one consumer representative, while the other 15 will be from hospitals and physicians.

You are going upstream, to say the least, in a process like that. As a result, I was denied access to that information in both States.

Rules are made by the people in power, and the people, who in the past have had the influence and the power, have been the providers themselves.

Health pages would appreciate any help in changing that structure.

Chairman WYDEN. Do any other panel members want to add to that?

Mr. SESSA. In Pennsylvania, Mr. Schneider did request information from us. We do make information available to consumers and organizations that ask for special information. But you have to make sure the information is accurate when you are reporting on physicians and hospitals. We did not give that information to Mr. Schneider simply because we had not yet been able to go to the additional length of looking at the attribution of the data submitted to us to make sure that each and every patient is attributed properly to the correct physician. We think it is our responsibility to do that.

When our information is out on the street, people can rely on the fact that it is accurate, factual information. I think that is extremely important. You cannot put information out there that is not crystal clear and accurate, and that has been gone through carefully. That information is available to the public in Pennsylvania.

Chairman WYDEN. I share that view. That is why we are going at this, opening up the data bank in a very careful kind of way. This is something our citizens have a great interest in. If you put out some faulty data, inaccurate data, you do a great disservice to what is in the consumer's long-term interests.

So, we have a situation where 37 States get information on costs and quality and only three of them make that information available.

Two of you are in business. In effect, you are entrepreneurs before the Small Business Committee. How did you get that data? Do you just sort of go out there and try to perform competitive tricks to pry it out of people? I guess Mr. Sessa is in a State where there is a law.

Mr. Schneider, what do you do? Do you try all kinds of unorthodox techniques to try to pry information out of people? This has all, I think, got to be somewhat mysterious to people because if you are going to buy some screws to work on a cabinet on a Sunday, for example, you can shop all over town for screws. You can find big heads, small heads, ones that glow in dark, and ones that don't glow in the dark. You can find out all kinds of things about screws.

But yet about health care purchases, based on what we have been told, even your testimony about the 37 States, you cannot get information in those places. I am curious. Instead of going about it directly as a consumer does when he is trying to find something in a hardware store, how do you go about getting this information and kind of pulling all this information out of the unwilling?

Mr. SCHNEIDER. Any which way you can. You try to gather from all the sources. Some of this information is available, especially the objective information like where physicians went to school and what prices they charge. That stuff you can either be getting from the doctors themselves, from hospitals, and the State licensing

board does provide some information. There are national directories that you can search through as well.

So, there is some information out there. Part of the problem right now is that no one has taken up the task of actually compiling that information, putting it together in an accessible format, and, most importantly from my perspective, actually marketing it to people because people are not out there right now asking these first questions about their physicians. I think you try to do what you can from where you can get it.

Concerning the quality of care provided, which is what we have been talking about this morning, there is more of a problem. There is very, very little quality of care information available to the public right now. The scary side of this is that doctors and hospitals have not been scientifically working on the quality side for a very long period of time. As a result of that, I think we are still in the first generation of trying to understand what quality of care information is out there.

I think some of the comments that have been made are true. You have to make sure that what you are putting out there is good information.

Where I am standing, though, part of the way that you improve information is by starting to use it and making sure it is as good as you can get, putting the proper caveats associated with it, and then putting it out there and letting forces, individual consumers, public agencies, et cetera, start using that information. That is the way I would think information will snowball. People will want more and providers will provide more.

Chairman WYDEN. Dr. Hannan, why did your State of New York decide to begin making comparative information available to the public?

Dr. HANNAN. Just because it came to the attention of a group advisory board and the New York State Health Department that there were major differences in outcomes in a particular surgical procedure, bypass surgery, and there was no way of determining the cause of these differences without actually, first of all, developing a system whereby data were collected that could enable one to determine whether the differences were the result of quality or just patient mix.

This gets at the previous question, which is, why is data not given out? One of the things you have to bear in mind is that on some occasions there is just not data available that is good enough to give out. For instance, in the case of bypass surgery, it was not a matter of "We have this information, should we now analyze it and give it out." It was a matter of a determination being made that no information existed that was good enough to truly evaluate differences in quality of care, and a whole new data system was developed for that purpose. Once it was developed and found to be a valid means of detecting differences, then the information was considered good enough to give to the public.

Chairman WYDEN. Dr. Mohlenbrock, in effect, you use your report card data to get the physicians and the hospitals rather than disclosing it directly to the public. What evidence is there that this approach is successful in producing improvements in the cost and quality of health care services for the consumer?

Dr. MOHLENBROCK. I think recently, over the last 3 to 4 years, the evidence that it is working is the radical changes that we see that are statistically significant in reductions in variation.

The example I gave you is in Cincinnati where we see C-section rates that are now falling. The variation between the hospitals are now coming together for all the reasons that people here are saying. If you get this data out there, people start to use it to affect positive changes. There is powerful stimuli for the physicians and hospitals to start to reason together to make these things happen.

Back to your question of where do we get the data. Because people like this committee, in years before, have given us Medicare data that is publicly available in its raw form, we can access raw data. The States that have been mentioned make these data sets available in their raw form. We get the data severity, adjust the information, and then take it down to the physician level.

Internally, it is working very nicely because physicians basically want to do better.

Chairman WYDEN. Let me ask you; this is a question we will face with our consumer agenda. We have 30 groups now, representing more than 30 million consumers, in a consumer rights agenda that we are going to be working for as part of the health reform. I indicated we are going to be working with Mrs. Clinton and the administration on this.

One of the issues that occurred to me, and I would like to get your thoughts on it, is that we don't want to see a conflict between the effort to have internal quality management, which it seems to me you all focus on—you try to get information to the hospitals, the doctors, and people who may have problems—which is data that they can use internally to improve their quality. We don't want to have any conflict between that and the effort to also have public disclosure so that the consumer who has been telling us this morning that they, and ultimately they, are the only person who can really fight best for them and can get access to information as well.

Do you see any conflict between these two? Is there any contradiction between internal quality management and getting data to the providers, and public disclosure so that the consumer can have information as well?

Dr. MOHLENBROCK. No; I see a synergism, because if you tell me for the reasons you have just said that we have to have better disclosure, and we want to see the outcomes of care improved. Don't tell me, a doctor, how to nail a hip, but tell me that for sure you are going to measure and monitor the outcomes of my care over time, we are going to be looking.

You, as the advocate for consumers, are going to be looking at the processes and the results of those processes and the outcomes. I think that is excellent. I think the more data we providers get to you that shows we are doing a better job in terms of reduction, variation, and outcome improvements, is what we should be doing and that is basically what I and my organization are dedicated to accomplishing.

I see it very much as a synergistic effect. The reality is nobody will hold themselves accountable unless somebody else asks them to. That is what has happened over the years. Whether it is the

legal or the medical profession, we all have to be held accountable to someone else. I think that is the whole point here.

Your efforts are excellent, in the right direction, and all we need is more of it.

Chairman WYDEN. Mr. Sessa, you have a business council. This is the Small Business Committee. It seems to me that you have picked up on the theme that has concerned me, and that is that consumers don't want to delegate their right to choose anybody else, whether it is an employee at a business or a staffer at a health maintenance organization who will say, "I will make the decision rather than giving you the information."

I gather that you all decided that a long time ago because you said we are going to give this information, not just to the businesses in Pennsylvania, but you are going to make it directly available to the employees of the businesses in Pennsylvania as well; is that correct?

Mr. SESSA. That is correct. Our council is predominately business, labor, and consumers—not just business. The reason we did that, Mr. Chairman, was because of the issue of people in Pennsylvania very strongly wanting to be able to choose their physician, very strongly. We wanted to give them information that could help them do that as well as start a dialog.

The patient-physician relationship is one that was going one way. The patient would listen, the physician would talk, and nobody would ask questions because they were too intimidated.

We have given them information from which now to start that dialog so they can start to ask questions. They can look at their employer, and the employer can say we have chosen this particular hospital and physician to belong to our network, not because they are cheap, but because they do good work, they have good services, and good outcomes. The employer can show this to the employee. Business and labor both have information that is public that will indicate the efficient providers and the ones that do well, and that's the ones we are choosing for our network. That is happening in Pennsylvania.

Chairman WYDEN. Let me ask you all one last question. I am going to go right down the panel. If you were in Congress now, and working on the Federal health reform effort, and you wanted to take one step to try to assist consumers to get good objective information so that they can make these choices that are so vital to them, what would you advocate if you were a Member of Congress?

Mr. SESSA. I would advocate that people look at a method that will be consistent so that you can compare information from one State to another, from one region to another, so that people are not comparing apples with oranges.

I think all the things you are hearing today are terrific and very necessary, but in order for it to work nationally, there has to be some linchpin where it all comes in, and we can mesh it together so we can see what is happening all over the country, not just in one particular area.

Chairman WYDEN. So, if there is nothing else, you would like to see a uniform system for gathering this kind of information, making it available to consumers, and then making sure it is distributed in an easily accessed way?

Mr. SESSA. Yes.

Chairman WYDEN. Dr. Mohlenbrock.

Dr. MOHLENBROCK. I will play off of what he just said. I would say not necessarily a common system, but let's use a common definition of "quality" that is both process and outcome oriented just like the JCAHO and the Office of Technology Assessment has given us. In other words, don't tell us what system to use or exactly what process to use, give us the impetus to do that by us sharing the processes and the outcomes of our care with the consumer and with Congress.

But let's not forget tort reform. That plays a major role for us, make no mistake about it.

Chairman WYDEN. Dr. Hannan.

Dr. HANNAN. I basically agree with the last two speakers, particularly Mr. Sessa. I think what needs to be done is to identify procedure by procedure and medical condition by medical condition what important information is needed in order to severity adjust so you can compare providers with different case mixes.

That needs to be done by a group of clinical experts who need to define the data elements. Those data elements need to be available across all hospitals, across all providers, and then used to compare performance.

Chairman WYDEN. Mr. Schneider.

Mr. SCHNEIDER. I will give a recommendation on a microlevel. I am a big believer that information can play an extremely effective role in creating competitive juices, both from the supply side, that being the doctors in the system, and the demand side, meaning the consumers.

To that effect, I like the process of identifying specifically caesarean section rates. It is something which the medical profession has said is an overused procedure. It is a very common procedure in this country and consequently would affect an awful lot of people.

I think if you would start getting people involved with seeing information on their doctors, they would start learning about the differences and start the whole process of getting consumers involved and providers more accountable in the future.

Chairman WYDEN. You all have been very helpful. We would ask more questions, but we are probably going to be here until dinner time as it is. Thank you very much.

Our next panel: Gail Shearer, manager, Policy Analysis Division, Consumers Union, Washington, DC; Bente Cooney, National Committee to Preserve Social Security and Medicare and chair, Working Group on Consumer Information, Coalition for Consumer Protection and Quality in Health Care Reform, Washington, DC; Sidney Wolfe, M.D., director, Health Research Group, Washington, DC; and Laura Wittkin, National Center for Patients' Rights, New York, New York.

We welcome all of you. We thank you for the help that you have shown this committee in the past. Many of you have given many hours to the subcommittee's work on a variety of issues over the years. We are very appreciative.

As I think each of you is aware, it has been the practice of this subcommittee to swear all the witnesses who come before the

panel. Do any of you have any objection to being sworn as a witnesses?

[Witnesses sworn.]

Chairman WYDEN. We are going to make your prepared remarks part of the hearing record. I would like to ask you to try to take 5 minutes or so in order that we can stay on schedule.

Ms. Shearer, we welcome you. It has been a pleasure to work with you over many years. Not long ago, we had a great success on the medigap insurance reform issue to stop some of the ripoffs in these private health insurance policies sold to seniors. When we started that effort, there were a lot of these policies out there that were not worth much more than the paper they were written on. You all have helped us on many issues, and we appreciate it. Why don't you please proceed?

TESTIMONY OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Thank you, Mr. Chairman. Your leadership on the medigap issue and others has been invaluable, and we really appreciate that.

As you know, Consumers Union is dedicated to the principle of informed choice, and we commend you for all the efforts that you have done to further this goal for health care consumers.

This hearing has already explored some very important issues, issues such as improved quality control of providers, the need for increased information about providers for consumers, the need for improved accountability to consumers, not insurance company bottom line when it comes to utilization review, and access to full information about providers.

The main issue that my testimony will address is consumer preferences with regard to freedom to choose their own doctor. Before summarizing the key findings of a recent Consumers Union Gallup poll on this issue, I would like to outline the principles that Consumers Union supports as the key elements of health care reform. These are the components that we will look for in the administration's forthcoming health care proposal and any future congressional proposals.

To meet the needs of consumers, any health care reform plan must offer: Universal, quality health care—with comprehensive benefits—for all U.S. residents regardless of age, income, employment status, or health status; cost containment with a national health care budget and control over wasteful paperwork and procedures; fair-sharing financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis; public accountability with consumers well represented on all boards overseeing health care; and consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

On April 20, 1993, Consumers Union released results of a survey that explored consumer preferences on health care issues, with several questions that explored views on consumer choice of doctor in detail. The survey was conducted for Consumers Union by the Gallup Organization on March 26 through April 9, and 1,006 heads

of households were asked a number of questions about viewpoint on various health issues. The findings about preferences on choice of doctor were dramatic and show very clearly that most Americans care deeply about choice of doctor. They want the freedom to choose their own doctor when they are healthy, and they want access to the best medical care when they are sick.

The survey found: Of the consumers surveyed, 85 percent responded that choice of doctor is very important or somewhat important; they want the option to choose a doctor on their own rather than selecting one from a list provided by a health plan; Americans want to choose their specialists. When illness strikes, people want the freedom to choose the specialist they think can provide the best care. More than 9 out of 10 Americans polled, 91 percent, said it is very important or somewhat important to select a specialist without being restricted to a list provided by a health plan. People are willing to pay more for health care if they can choose their doctors and specialized medical care centers. Fully 43 percent of people surveyed with and without family health care coverage are willing to pay \$25 or more per month—\$300 per year—to preserve the right to select a physician, and 51 percent indicated that they are willing to pay this amount to ensure access to treatment at any high quality, specialized, medical care center. Freedom of choice is important to low-income families. Even though their pocketbooks may be strained, 41 percent of families earning less than \$25,000 a year are willing to pay \$300 a year or more for health care if they are able to pick their physicians. People care about choosing a doctor, not about which insurance company covers them. Consumer choice means more than shopping around for a health plan. It means freedom to choose a doctor, and 73 percent of Americans polled said they care more about choice of doctor than choice of insurance company. Even people who are enrolled in health maintenance organizations [HMO's] and preferred provider organizations [PPO's], insurance plans that typically restrict freedom of choice of doctor, value freedom to choose their doctor. Of people enrolled in HMO's, 78 percent responded that freedom of choice of doctor is very important or somewhat important to them, compared with 81 percent of those enrolled in PPO's, and 91 percent of those who are covered by a traditional insurance policy.

The strength of consumer feelings about the importance of freedom to select primary care doctors, specialists, and specialized medical care centers has important implications for national health care reform. Any health reform proposal that fails to recognize that consumers want to choose their doctor—not their insurance plan—will never gain the public support needed for enactment of comprehensive reform.

Consumer choice of doctor matters to consumers because doctors' skills vary and consumers want access to the highest quality care. Before they enroll in a health plan, consumers need full and understandable information about the qualifications of primary care doctors if the health plan limits the selection of primary care providers. They need comprehensive information about alternative health plans, information that could be summarized in a "report card" that would allow comparison between plans.

We enthusiastically support the chairman's efforts to enhance the effectiveness of the National Practitioner Data Bank by allowing the public access to the information concerning the professional competence of physicians.

Consumers Union is committed to broadening the scope of the Health Care Quality Improvement Act of 1986 [P.L. 99-660] so that not only will the public continue to enjoy a choice of doctors but it will have a meaningful choice as well.

Special protections are needed if a health plan limits choice of specialist or access to specialized medical centers. Choice of primary care doctor for healthy consumers raises one set of issues about needed information. A more challenging public policy problem is posed once a family is enrolled in a health care plan and serious illness strikes. It is clear from our survey that this fear of limited choice, once illness strikes, is on people's minds. When medical treatment can make the difference between life and death, consumers want to know that they can have access to the best care for their families and themselves. The prospect of seriously ill consumers being locked into second rate care, based on a choice they made when they were healthy, raises troubling issues.

One modest protection that should be built into health reform would be full disclosure to consumers of the extent to which plans limit access to specialists and access to specialized medical care centers such as the Mayo Clinic. Another protection that should be considered is building in some flexibility, with the possibility—fully disclosed of course—that should serious illness strike, consumers could have access to specialized centers or specialists outside the plan, for a modest increase in cost-sharing or premiums.

As bad as a onetime need to change primary care doctors could be, it is crucial that health reform not require consumers to make regular, even annual, changes in providers.

Low-income consumers care deeply about freedom to choose their doctors; low-income consumers should have the same range of health care options that high-income consumers have, to avoid a multitier health care system.

Thank you for providing Consumers Union with this opportunity to present these findings to the subcommittee about consumer support for key elements of national health care reform.

[Ms. Shearer's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Thank you. It is very helpful, and I will have some questions in a few moments.

Chairman WYDEN. Ms. Cooney, why don't we go to you. Thank you for all the good work that you have been doing on this effort to put in place a strong consumer coalition.

TESTIMONY OF BENTE COONEY, CHAIR, WORKING GROUP ON CONSUMER INFORMATION, COALITION FOR CONSUMER PROTECTION AND QUALITY IN HEALTH CARE REFORM

Ms. COONEY. Thank you, Mr. Chairman. I am Bente Cooney, senior policy analyst with the National Committee to Preserve Social Security and Medicare. Today, I am here to testify as chair

of the Workgroup on Consumer Information for the Coalition for Consumer Protection and Quality in Health Care Reform.

The consumer coalition consists of more than 30 members and supporting organizations. It was started earlier this year and has grown rapidly over the past few months. Consumers are concerned lest health care reform's focus on costs-capping, reducing and managing the cost of a new health care system overshadow the critical need for quality assurance and consumer protection.

Consumer information is important in any health care system, but it is especially essential in a health care system based on the theory of managed competition. The concept assumes consumers will stimulate high quality and low costs through their choices of health care plans and providers. Consumer information is a potentially powerful tool that could give consumers increased control over their own health care. However, consumer choices will be only as good as the data provided.

Quality of information. Consumer information should be managed by entities independent of the health plans and the health alliances. A national entity such as a national health board should be responsible for: One, establishing uniform data formats; two, setting standards for collecting and analyzing data; and three, determining how the data should be distributed on the national, State, and plan levels. It is essential that the data and information be accurate, reliable, comparable, timely, and easy to understand. It must also be available in different languages and formats for people with special challenges such as the visually impaired.

We want to make it clear, however, that even good consumer information will not eliminate the need for appropriate grievance and appeals procedures, internal and external quality assurance, and external, independent oversight and monitoring of the health care system.

We believe that consumer information must be more than a "report card." Perhaps a better description would be a "consumer guide" for plan selection and use.

There are probably hundreds of ways to present information to consumers, but, at this point, we envision four main categories of information: One, plan-specific descriptions; two, plan-specific quality report cards including enrollee surveys; three, provider and practitioner-specific descriptions; and four, condition-specific provider and practitioner quality reports cards including enrollee surveys.

The first two categories, plan-specific descriptions and plan-specific report cards, would be primary elements of the consumer guide, while the third and fourth categories would be available on request.

I refer you to the attached draft white paper on Minimum Requirements for Consumer Information, which is being developed by the coalition for a more detailed discussion of these categories. We would appreciate it being included in the record.

Chairman WYDEN. Without objection, we will enter it into the record.

[The information may be found in the appendix.]

Ms. COONEY. The first section of the consumer guide should describe plan configurations, how the health care delivery system

works, how to use the consumer guide, how to appeal a health care decision, how to resolve complaints, and how to contact a health ombuds or counseling program. Next, they will need to know premiums and other out-of-pocket costs, and the benefits and services of each plan option. The goal is to enable the consumer to compare health care plans in a given health alliance.

Examples in this category would be: Out-of-pocket costs; cost of using services outside the plan; policy on using services outside the plan; benefits covered; service locations; and rate of board-certified physicians.

The center piece of the consumer guide should be a report card comparing plans based on quality indicators and results of enrollee surveys indicating satisfaction rates among current users. When appropriate, national averages should be provided for comparison.

In addition to including performance measures such as percent of enrollees who have received preventive care, for example, annual physicals and mammograms, the report card should list indicators of undesired occurrences, such as inappropriate use of medication, readmissions within certain time periods of hospital discharges, and hospital-acquired infections.

A standard survey should be developed to measure satisfaction among health plan participants. It could have some regional, individualized characteristics, but the main body of the survey should be consistent across the country so that it can be used for national comparisons.

The survey should be short, clear, and contain questions related to acceptability, availability, and accessibility, such as: Overall satisfaction with care received; convenience of location of doctors and hospitals; excessive paperwork or bureaucratic hassles; length of time spent in the waiting room; length of time spent with the practitioner; and degree to which questions were answered.

Also, information about disenrollment and the number of enrollee complaints would be an indication of satisfaction/dissatisfaction with the plan.

Further details on plans and their health care professionals should be provided on a per-request-basis, either from the plans themselves or from the health alliance. For example, if a consumer is trying to decide between plan A and plan B, he or she may want to review a more detailed description of the plan written in a standardized format to be determined by a national entity.

Information, such as fact sheets on each of the physicians in the plan, their training, years of practice, board certification, faculty responsibilities, and confirmed disciplinary actions, such as repeated malpractice payments, would be provided in this documentation. Fact sheets on individual hospitals with lists of services and other details should be available. The same type of information could be developed for home health agencies, laboratories, pharmacies, and other contracted health providers.

Condition- or treatment-specific information is important to the person who faces a major operation or health care decision and should be available upon request. This information is different from the plan-specific information in that it includes both hospital- and physician-specific practice profiles and outcomes data on a particular procedure or condition.

This is similar to what has been done, as we heard earlier today, for coronary artery bypass graft surgery in both Pennsylvania and New York. The information could be presented either on a nationwide or a regionwide basis and could be available from the national health board or its designees. The data should be appropriately adjusted for severity to avoid skewing outcomes for surgeons and hospitals serving a more valuable population.

For a particular condition, this data could include: Number of surgeries performed by hospital or by surgeon; and death rates within certain time periods.

Information obtained through the enrollee satisfaction surveys which addresses condition-specific provider and practitioner quality and outcomes should be part of this report card.

Conclusion. Consumer information must be developed with the consumers' needs in mind. Information should be available in written, verbal, and electronic forms. It will need to be available in different languages and forms for challenged populations. Independent health care counseling should be available to assist consumers when necessary. The success of health care reform is largely dependent on the ability of consumers to make wise choices and influence the quality and cost of health care. Therefore, the plans must provide the consumer with the necessary tools for good decisionmaking. This will require resources, but we believe it is a cost-effective investment over time.

Finally, good information and decisions alone will not ensure quality care. Quality assurance measures, grievance and appeals procedures, and independent, external entities must be in place to monitor quality and enforce standards.

The organizations that are working with the coalition stand ready to work with you on these and other consumer protection issues in health care reform.

[Ms. Cooney's statement, with attachment, may be found in the appendix.]

Chairman WYDEN. Ms. Cooney, thank you. It is very helpful.

Chairman WYDEN. Dr. Wolfe, welcome. We thank you for the cooperation that you and Public Citizen have shown the subcommittee.

TESTIMONY OF SIDNEY M. WOLFE, M.D., DIRECTOR, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP

Dr. WOLFE. I would like to start out by responding to a question you asked someone on the previous panel, which is, what is the nature of the barriers that have been erected to getting this information? It is ironic that literally 20 years ago next week we were in the process of collecting data for what was going to be the first doctors directory in the country in Prince Georges County in suburban Maryland. As we were collecting data, the doctors in Prince Georges County were threatened with loss of license by their State medical society on the grounds that information that showed differences between doctors was illegal.

We have come a long way since then. We sued the Maryland State Medical Society in Federal court arguing that this abridged the First Amendment, and the Federal Trade Commission beat up

on them on antitrust grounds, and at least directories of doctors, coming from wherever, are no longer illegal. Advertising has gone probably a little too far to the other side perhaps. But the barriers to information persist.

As you know, several weeks ago the American Medical Association passed a resolution calling for the dissolution of the National Practitioner Data Bank. So, whereas we are having a hearing to talk about opening up the data bank so that people, both patient people and doctor people, such as I, can have access to it, the American Medical Association, trapped in what we will have to describe as the earlier part of the 20th Century or the 19th Century, as we move into the 21st Century, wants to just dissolve the data bank.

I think the battle is on. The question is: Does the public support the idea that information, that was collected very carefully through the law that you helped to pass in 1986, should be abolished on one hand, as the AMA would like to have happen, or should we open it up so that some of the very useful information in there can be made public?

To give an idea at an aggregate level of what kind of information is in there, we asked the National Practitioner Data Bank for its latest report.

In a report dated June 18, 1993, these are the kinds of data that are in the data bank: For 6,435 practitioners, mainly physicians, there is some kind of adverse action including mainly State disciplinary actions but also 2,500 reports of people who have lost their admitting privileges to hospitals or had them restricted because, at the level where they are practicing, the medical staff does not think they are doing a good enough job; in addition, there are 41,000 practitioners, mainly physicians, who have had one or more malpractice payouts against them. It turns out we have started, as you know, our own national practitioner data bank in rebellion to the fact that the publicly funded one is kept secret. Ours is public. Our does not have certain kinds of data, it doesn't have malpractice payouts, it doesn't have the hospital licensing actions, but it does have other kinds of actions such as the State disciplinary actions.

When you look at the data, we see that doctors are being disciplined in the States for things such as misprescribing or overprescribing of drugs, substandard care, incompetence or negligence, personal history of drug or alcohol abuse, and criminal convictions.

For the first three that I mentioned, the majority of those doctors who have been disciplined did not have their licenses taken away, did not have them suspended, but they are still practicing medicine. So, physicians who have been incompetent and physicians, in some instances, who have been convicted of crimes are out there practicing medicine and, in many cases, injuring or killing patients, and the patients don't have the foggiest notion that something happened to these doctors.

The issue is not whether one tiny piece of information in the data bank, per se, should be used as a grounds for convicting a doctor, but anyone who wants to decide on a basis for going to a doctor, or, in my case, referring a patient to a doctor, needs to have the full array, and the data bank as it is currently constituted is

only the beginning of the kind of information we should have about doctors.

You have heard a lot of other kinds of things that should be in a data bank at the Federal or State level. If I wanted to refer you, Congressman Wyden, to another doctor, even though I am a physician, I cannot find out from the data bank whether this doctor has had his or her license in trouble with the State unless I go to the State. I cannot find out whether there has been one or many malpractice payouts. I cannot find out whether that doctor was thrown off of the staff of a hospital, because even though I am a physician, I am excluded from the data bank just as much as a patient is. I can find out about my own record. I am not in the data bank, I am happy to say, but the point is that I cannot use the data bank as the valuable resource for referrals that it could be.

In summary, there is valuable information in the data bank, and in the future there will be even more valuable information. It is inexcusable, as is currently the case by law, that there is not any access to it.

We strongly support efforts to open it up as promptly as possible and efforts to repel the antiquated notions of the American Medical Association that it should be dissolved and that patients don't have a right.

The battle is very simple. It is the patients' right to know this kind of information and more versus the doctors' right to hide and keep secret information that for a small fraction of doctors will show the public that there are problems. We are really talking about the small fraction of doctors.

In the data bank right now are fewer than 10 percent of the doctors in the United States. As you said repeatedly during the hearing, most doctors are practicing good medicine, and those doctors should not be in the least bit concerned about having information made public about their peers who are giving medicine a bad name and causing other problems.

Thank you.

[Dr. Wolfe's statement may be found in the appendix.]

Chairman WYDEN. Dr. Wolfe, thank you. I will have some questions in a moment.

I think those numbers are consistent with what we picked up as well and are very revealing. You say there are more than 500,000 physicians in the United States. You all have numbers between 6,000 and 7,000 which is in line with what the subcommittee has. The vast majority of doctors in our country clearly are in line with what we have been discussing here, and that is the professional standards that the public has a right to expect.

What we are talking about is a very small fraction. I will have some additional questions in a moment.

Ms. Wittkin, we thank you. You also have been very helpful to us in terms of preparing for the hearing. We appreciate that. Please proceed.

**TESTIMONY OF LAURA WITTKIN, EXECUTIVE DIRECTOR,
NATIONAL CENTER FOR PATIENTS' RIGHTS**

Ms. WITTKIN. Good afternoon. My name is Laura Wittkin. I am the executive director of the National Center for Patients' Rights, which is a malpractice victims' and patients' rights advocacy and support group.

I would like to thank you for inviting us to participate in this hearing today to examine the need for consumers to make informed choices about their practitioners, their providers, and health care plans. This is certainly an issue of paramount importance to anybody seeking health care in this country today.

The Center for Patients' Rights assists victims and medical consumers throughout the country. We have chapters in Massachusetts, New York, and West Virginia. We receive about 200 phone calls a week from consumers across the country, and 85 percent of the calls that we get are from people who have been already harmed by poor care.

In addition to their seeking victim support, guidance with how to file a complaint, and how to exercise their legal rights, they are also often desperately ill, in need of medical attention, but unable to find proper care and attention.

They have lost faith in the profession and in their own ability to judge whether a physician is competent or not. That is classic of malpractice victims. But no matter why people contact us initially, in the end, most consumers share a common frustration and apprehension about the lack of public access to quality-related information. They contact our group hoping that we can provide them names of doctors and hospitals or show them how they can find those doctors and hospitals. But the fact is that, for the most part, we cannot help them.

The reality is that despite the fact that we live in one of the most technologically and scientifically advanced countries in the world, it is virtually impossible, as you have already heard here today, for consumers to find out about the quality of health care providers.

Although it does sound like a cliché, because we have heard it so many times, it is true, we do know more about our toasters, our TV's, and our cereals than we know about the doctors in whose hands we place our lives and the lives of our loved ones.

Trying to uncover this information really takes the expertise and the perseverance of a detective. Our organization attempts to provide consumers with the information that is out there and available, but it really is not easy. We provide information such as: How to check on your doctor by looking at their State medical board records; how to attempt to find out about malpractice information; and how to attempt to find out if a doctor has had a problem in a hospital, as well as information about hospital affiliations and board certifications.

Generally, State medical boards provide very limited information. If you don't ask the questions in the right way, you either don't get the answer or you get the wrong answer. That is really a problem. It is like having to speak 51 different languages when you

deal with State medical boards. Everyone has their own rules and ways of operating.

In addition to providing some disciplinary information, at least half the State medical boards in this country will give you information about doctors who have been formally charged with medical misconduct. But again, if the consumer does not know to ask the question, and most don't, they will not be provided with this information.

About a handful of boards out there also provide some information about malpractice-related data. Again, you have to know how to ask the question, or you won't be told. Most of the malpractice information that is provided by the State medical boards is very sketchy information. They don't keep up to date in terms of making sure they get the information from the courts or from the insurance carriers on a timely basis so that they have the most current information. So, if you are calling to find out about a doctor, you may or may not be getting accurate information. Checking on a doctor's malpractice history is usually a very daunting and, at times, undoable task.

Depending on where you live, you may or may not be able to go to the court house and find out about some malpractice cases against your doctor. Some courts file cases by plaintiff only, others by defendant only, and some courts cross reference. If a court files by plaintiff only, which is the case with many courts in this country, you cannot access information about doctors unless you have months to spend and resources available to do a very extensive courthouse search.

If a doctor works in more than one county in a State or has moved from one part of the State to the other or even from another State, consumers are going to be missing a vitally important piece of somebody's practice pattern and malpractice history.

Finding out about doctors who have had problems in hospitals is also virtually impossible unless the incident ultimately resulted in either an action by a State medical board or some sort of a public lawsuit. This really presents a critical problem for medical consumers out there because it is common for doctors who lose privileges in one hospital to still be able to get privileges or retain privileges in other hospitals.

Again, this leaves consumers totally unaware and vulnerable. Even when a State medical board does take an action based on something that happened in a hospital with a doctor, we know how slowly those wheels turn, and it can literally take years before that doctor is publicly identified as someone who is a dangerous practitioner.

People interested in learning more about their hospitals also face frustration and disappointment pretty much across the board because there really is a void of information out there.

Comparative data, which you already heard about this morning, while promising, is still in its infancy and will take years to fully develop. States which are already producing some of this information, like New York, for example, have not been able to ensure that consumers are actually getting access to this data.

Anything we look at in terms of creating these outcome data programs must also include some plan to ensure that those people who

needed information programs and can benefit from them, will actually be able to access them. Most people cannot rely on hospital oversight agencies to provide either publicly disclosable, easily available, or even reliable information about hospitals.

As far as managed care plans are concerned, there really is a dearth of information out there about the quality of HMO's and other managed care plans. Even though things are slowly beginning to open up, it will take a while.

When I was listening to Ms. Perez earlier today, I was really struck by what she said because I have had to personally intervene on behalf of medical consumers in a number of States who have been subjected to the same kinds of inhuman abuse and mistreatment that Mrs. Perez has received at the hands of her HMO. I think it is absolutely disgraceful.

If the Clinton health care reform model becomes a reality, and we certainly hope it doesn't in its current state, informed consumer choice will play a key role in ensuring and improving quality of health care in this country. Under this model, which emphasizes cost control and strips away the individual freedoms and rights of consumers to make choices about practitioners, it is essential that consumers have access to information about the quality of their providers' care. This data will enable us to better identify those doctors who will be most appropriate for our needs.

It is not acceptable or advisable for employers alone to have access to this comparative data. Too often, employers and health care plans' bottom line is money. But the consumers' bottom line, as you have heard here all morning, is ensuring that there are good, competent practitioners out there caring for themselves and their families. Health care, frankly, is too important an issue to leave in the hands of a middleman.

Even though the idea of the comparative data is new, the idea of keeping data out of the hands of consumers, unfortunately, is not. I know you have heard about the coronary bypass procedure data in New York State, which is really quite wonderful, but NY doctors are hard at work right now trying to get the names of the individual doctors shielded so that they are no longer identified in the outcome data reports. If that happens, obviously, it will greatly diminish the usefulness of that data and once again leave medical consumers out there on their own, unable to make important, informed decisions about their care.

In addition to having access to comparative data, which we think is wonderful, and we certainly should be looking to expand that area, we also need access to the National Practitioners' Data Bank or doctors like Steven Dell will just continue to harm, kill, and maim innocent patients across this country.

The information in the data bank should be accessible in its entirety in order to provide a useful profile of a practitioner. In our written testimony, we have attempted to outline for you how unbelievably difficult it is for most of us who get information about doctors and hospitals. Access to the information from a centralized source such as the data bank will save time and money, but most importantly it will save lives.

As we move into this new age of health care delivery in this country, our Government must strive to create the best possible

system with accurate comparative data that has been properly risk adjusted, and they must ensure that the public is not left out of this process. It is essential that both outcome data and information from the National Practitioners' Data Bank be available on line and easily accessible through libraries, doctors' offices, hospitals, and by telephone.

Our Government must also make certain that there are ongoing outreach and education programs to teach consumers how to make the most of this data as well as to learn more about what their rights are and how to exercise those rights in a new health care model.

We have a growing epidemic of medical malpractice in this country. It is a problem I know all too well. This is what CPR does all day long—deal with victims. All of us at the center for Patients Rights have had personal experiences with malpractice. It is an epidemic. The Harvard study's figures are horrifying; at least 90,000 people a year in hospitals die from malpractice. We wonder how many more families will have to endure what the Bennetts have or the what the Millers or Ms. Perez have. How can we even consider making such a dramatic change in the health care system in this country without first placing quality at the top of the health care agenda?

Our legislators and Government officials must recognize and support the need for consumers to be empowered with information to protect themselves from dangerous practitioners and make the best possible selections for their health care.

[Ms. Wittkin's statement may be found in the appendix.]

Chairman WYDEN. Thank you for excellent testimony.

You all, in effect, are really on the street, in the sense that people come to you. All of you have given excellent testimony.

Ms. Wittkin, I will start with you. I personally am encouraged and optimistic about this time, frankly, as it relates to the consumer rights agenda. I think we have a very strong hand to play around this argument, that if you are going to create all these health alliances and you are going to have some form of managed competition, you have to give people the life blood—they have to have access to the essence of what is going to make it work—which is good information that is objective and up to date. It must not have the kind of lag time that you are talking about.

I have made it very clear that I am going to push hard to make this a key building block of any reform efforts.

Why don't we start, and each of you touch on this, with you, Ms. Wittkin. What do you think the most important information ought to be as it relates to consumer rights?

I would obviously want to get the widest array of good and objective information that I can as we go through this reform effort, but, obviously, I ought to try to get the most important aspects, the kinds of comparative data out there and get that in this reform effort as quickly as possible.

Would this include things like the rate of payouts or sanctions? What would be the three or four areas of data based on the work that you do at the patients rights center that are absolutely the most important in terms of consumers rights in this national bill?

Ms. WITTKIN. We are asked about malpractice and disciplinary information most. That probably reflects the atmosphere out there, and also the fact that there is not any other kind of data available. People are looking to protect themselves from harm, and they want to know who the bad guy is, so to speak.

Most of the information that people come looking for has to do with punitive things, but that doesn't mean we don't feel equally strongly about the need for good outcome and comparative data.

I am someone who has to call on the medical profession often. I have a rare disease. I also was a malpractice victim. I need a lot of medical care and attention. I think it is as important to have information about what people and facilities do well as it is about the punitive information. I don't think you can sacrifice one for the other or merely concentrate on one and not do the other.

It will take time to develop the comparative outcome data, although we are making inroads. In the meantime, people need to know who the bad doctors are and what substandard facilities are out there. I cannot choose one above the other.

Chairman WYDEN. Ms. Shearer, what would be your priorities in terms of access to information in the national bill.

Ms. SHEARER. I would start with basic medical malpractice information. But on top of that, and this is especially important for surgeons and specialists, information about the number of times they have performed different procedures such as cataract procedures or whatever type of operation and their success rate in performing these procedures.

Another type of information that would be helpful would be information on the percentage of births done by caesarean for different providers. I am scratching the surface. I think for all providers, be they doctors, HMO's, or health plans, we need a very comprehensive, full array of information to allow consumers to make an informed decision.

Ms. COONEY. Clearly, the consumers need to know about the practitioner providing the services for them. Additionally, now that we are moving toward a prepaid system, it is important for consumers to know a lot about the prepaid plan they may be joining. What are the policies about going outside the plan? What are their choices within the plan?

It is important for them to access information about an individual practitioner in that plan, so they can compare a practitioner in one plan with the next plan before they decide which to join. Once they are in a plan, and they become ill, they need to know what are some of the outcomes of individual practitioners and what are their profiles, as well as that of the hospital. We must not ignore the hospital and the other providers, nursing homes, home health services, et cetera.

Chairman WYDEN. Dr. Wolfe.

Dr. WOLFE. I agree, one should not say we can only have this or this. It should be all of the above. As they are tested and are shown to be accurate and useful, they should be accepted.

We think about Canada which is a single-payor system. They tried it in Saskatchewan before going national. We had the experiments in New York in a more limited way, and in Pennsylvania, the more extensive way of implementing and putting out informa-

tion that describes at the level of the hospital and the individual doctor how they are practicing.

Ultimately, that should be added to, layered on, the kinds of information that is now in the data bank, although one of the kinds of information that should be in the data bank is not in there, and that is the hundreds of doctors who have lost their narcotics license from the Justice Department's Drug Enforcement Agency or had it restricted. It has been 3 years since the data bank went up, and that is not in there. Our organization had to file a lawsuit to get this information so we could put it in our data bank.

It is not difficult to identify those kinds of data that have been deemed important for people to use and put them in what would be hopefully a single data bank, accessible to people in a State and for those practitioners and providers in that State, but really in a uniform way.

I agree with the question you asked the last panel, that it should not be apples and oranges. It is interesting to note that panel represented two public and two private efforts to collect and disseminate information. In three of the four, it was made public, and for one it was just sent back to the doctors themselves.

One of the disadvantages of having 1,000 different insurers is that everyone collects data using different criteria and it has different meaning. The recent score card put out by United Health Care made it look good for those who should, in their view, use that plan. I think it has to be made uniform as much as possible, and, as more layers are validated, they need to be added on.

By the millennium, in 2000, I suspect we will have a national practitioner data bank score card, whatever you want to call it, that is much more useful and accessible than we have right now.

Chairman WYDEN. In this new health care landscape, who ought to be the advocate for the patient? You listened to Mrs. Perez' account. Basically, what you walk away from is that in a lot of these plans, at a time when you are ill, you don't feel well, and you don't have your strength, you have to gird your strength up for some kind of bureaucratic battle with the plan itself just to secure your rights.

I am sympathetic to a number of consumer groups that have called for health care ombudsmen and things of this nature. You say to yourself, what can be done to require the plan to be more sensitive initially. Certainly the health care ombudsmen is useful, but it would be another layer to try to compensate for a plan not doing what it should.

What can be done to make sure that someone like Mrs. Perez has a strong advocate who will fight for her rights so they don't have to battle with them when she is sick, without just adding another layer on here?

Ms. WITTKIN. That is very difficult to answer. The problems with the way these managed care plans are set up and respond to patients needs has to do with the kinds of incentives there are in these programs, the salaries of the employees not being adequate compared to what the profits are for some of these groups. These problems reflect some of the most fundamental problems we are seeing with health care in this country today.

The practice of medicine is very different from what it was when I was young. There seems to be reflected in medical care today the same kind of sort of "me," "greedy," "yuppi" problems that we saw in the 1980's.

The profession has changed. It is a business. I don't know the best way to reverse those trends. Obviously, we are looking at paying close attention to developing primary care practitioners in this country and training them to deal with families. Dartmouth, with the cooperation of C. Everett Koop, has undertaken a new program to teach doctors to be more compassionate to patients. It is a very sad commentary that we have to go to those lengths right now to teach a doctor how to communicate with patients and how to be a compassionate provider, not just a well-skilled or a technical provider. I don't have the answer.

Chairman WYDEN. Ms. Shearer.

Ms. SHEARER. I would like to answer at several different levels. I think we have a unique opportunity to design a health care system that is accountable to consumers. Consumers have to be their own advocate, and they have to be given the tools that will enable them to be their own advocate. For example, there should be clearly defined appeals rights when the care that their doctor recommends is denied by whoever.

Second, the doctor, the provider, should be an advocate for consumers. Instead of spending too much of their time with telephone calls with utilization review companies, the doctors should be able to spend more time with patients and serving their needs.

Third, accountability to consumers should be built into the structure of health alliances. Any boards for health alliances should have heavy representation from consumers and should build in accountability to consumers at every level.

Chairman WYDEN. Your point about the alliances is something I feel very strongly about. If these alliances are just warmed over versions of the status quo, where you have the same old gang of economic interests, the insurers and the providers calling all the shots, that is not going to be reform.

One of the things I would push hard for is to make sure there is that healthy dose of consumer representation on these alliances, not a modified version of what is there now. Mrs. Cooney.

Ms. COONEY. I can only echo what Gail Shearer just stated. This is the position of the consumer coalition, and we work closely with the Consumers Union. There must be grievance procedures. There must be internal as well as external procedures for consumers of health care prepaid systems to be heard. There must be an ombudsman program, a counseling program where a person can get an outside advocate negotiating for them. There must be a method to count the complaints and to show as part of the report card so that other consumers can tell how many complaints there have been in a particular health plan.

Chairman WYDEN. Dr. Wolfe.

Dr. WOLFE. Dr. John Ware at New England Medical Center has pioneered over the last 4 years the science of measuring patients' satisfaction with the doctor-patient relationship, and it is validated in questionnaires to patients. They are very good judges of whether their doctors are treating them well.

This should be done in a very objective way where every doctor has a sample of his or her patients polled every couple of years and the outcome of that is incorporated as part of the National Practitioner Data Bank.

There seems to be institutional changes. We have discussed with people in the Clinton administration the idea of enterprise liability for the health alliances. I think the biggest nightmare, and Mr. Ira Magaziner agrees, is if they are taken over by the providers, and that is almost guaranteed.

Back in the 1970's, there were health planning agencies that were supposed to be acting on behalf of the patients to stop the proliferation of the 300,000 excess hospital beds and extra equipment. What we propose, and what has worked in the utility regulations field, are called consumer utility boards.

In Illinois, for example, a board funded by voluntary contributions by the ratepayers, who are polled every year or so to see if they want to contribute their \$5 or \$10, has saved \$3.5 billion by challenging the utility power structure.

We think the health alliances cannot work as they are presently structured. They are not going to be able to work in a provider-dominated atmosphere unless an other outside is soundly funded, staffed with health professionals, epidemiologists, and others.

We have the citizens health board. We seem to have gotten some agreement from the Department of Health and Human Services and the administration that this needed to be relied on. They cannot rely on the health alliance themselves. That is a structure of accountability. Otherwise, it will crumble as did the health systems agency 20 years ago.

Chairman WYDEN. We can debate the mechanics. In my conversations with Mrs. Clinton, she was very sympathetic to a heavy dose of consumer representation. I am optimistic with respect to the administration's language in that regard.

If we have any problems in the health committee, and I have to offer an amendment to put consumers in the majority, we will put out the call to all of you to help us line up support.

Let me ask a question that I feel very strongly about. That is the issue of the individuals' responsibility in this whole debate about using information and getting access to information. I think Ms. Shearer knows that I was codirector of the Gray Panthers for about 7 years before I got elected to Congress. Senior citizens worked hard for the generic drug law. Oregon was one of the first States in the country to get it. We know the generic is usually the same as the brand name, and you can save a chunk of money. Often I am in line at the pharmacy at home and see the pharmacist with a nice smile. There is a big sign that says you can get the drug with generic ingredients and yet nobody asks about it, though in theory you have an important victory to save money for consumers.

I would like to know what you think should be the individuals' responsibility in terms of using this information and how the individuals figure into this.

Ms. WITTKIN. Just to use the generic drug issue, as an example, over the last few years news stories and articles came out about companies that were producing very shoddy generic drugs. As a

result, the medical community became concerned. Based on those exposes many doctors and patients became concerned about relying on certain generic drugs.

Also when consumers go to a doctor and the doctor prescribes something, the doctor should be educating the consumer about whether or not the generic is acceptable or whether or not they would prefer that person get the product name.

The problem about getting the information out to the public, I think, is a problem that we are looking at no matter what area we are talking about. It is amazing that most people don't know what a State medical board is or how it operates or where it's located. I know that we do need to do something. I think some of the responsibility for going into communities and educating the public is going to be on the shoulders of all of the groups that are out there advocating for health care, and dealing with health-care-related issues.

There is so much free air time available, and we have attempted to encourage our State medical boards in the States where we have chapters to get information out to the public, to do aggressive outreach, but they have not begun to do it.

I think consumers have a tremendous amount of responsibility, and they should attempt to educate themselves. But they have to be met halfway. I don't think that has happened yet.

Chairman WYDEN. Ms. Shearer.

Ms. SHEARER. There are consumer responsibilities at several levels. I would like to comment on one key one and that is the obligation to vote with their feet. When it comes to medigap, now there is the ability to compare apples and apples and choose the lowest cost option available.

About doctors, I think this is in the consumers' self-interest to avoid those who have a bad malpractice record. I think you can count on consumers to again vote with their feet and find the highest quality doctor.

Ms. COONEY. Yes; I do believe we have an increased responsibility to stay informed. When I look at the members of the older generation where I came from, in Denmark, they did not question their physicians. They never asked questions about the hospital. Now, in a much more complicated environment and culture, we have to stay informed. It is a tremendous responsibility.

There is an added responsibility on consumer organizations to help consumers stay informed. I think that is why we must strive for the need for a counseling program, for ombudsmen programs that can help people who may not be able to absorb all of this information which, of course, should be presented in a standardized and comparable form.

We must have that outside assistance. I stress the stratified information so that you have the information when you need it. When you become ill, you want that information about who is the best practitioner.

Chairman WYDEN. Dr. Wolfe.

Dr. WOLFE. I want to comment a little on what Mrs. Cooney just said.

Newsday, having won the lawsuit against the New York State Health Department, published the data. But unless you happen to

have needed the bypass at that time, surgery on the day the article appeared, you probably did not see it.

We need to have recognized the notion that when your doctor tells you that you need bypass surgery and you get the second opinion, as you should be doing, the doctor should then say these are today's most recent data on the comparative mortality rates for the hospital or doctor that you are considering using. You will notice I am the worse, do you want to go to me, or I am the best, do you want to go to me?

It sounds crude and funny but that is the point. When a woman is in labor, she winds up having a 40-percent chance of a C-section at one hospital instead of a 10-percent chance of a C-section rate at another hospital. If I am a patient, I want to know that. Unless I find out, I may be harmed. I have never met anyone who, when they are apprised of the fact that there is a tenfold difference in rate for C-sections, doesn't want to find out.

I think, basically, a terrible job has been done in getting the information out. Even in Massachusetts and New York where there is a requirement for hospitals to disclose their C-section rate, I don't think a lot of patients know about it.

Chairman WYDEN. I think that is a very good, important point. What you are saying is that access to good objective information ought to be available on what amounts to a reasonable demand basis. It should not be available just once a year when you are signing up for a plan. It should be available when you need it rather than when you are flat on your back because you are seriously ill.

I think, Mrs. Wittkin, your point about the Federal Government meeting consumers halfway is critical. The Federal Government has not been a very good partner in terms of assisting consumers. That is why we want to open up the data bank. A lot of this will help hold down the cost of health care.

I think the other point that was helpful, Ms. Shearer, is that the medigap plan was a model in terms of what you do in terms of making a managed competition system work. The consumer group, after years and years of substandard insurers, got a standardized system. You can be sure I would hold out the work you did with us on medigap as an example of how you go about creating a system that has a role for a marketplace as opposed to a warmed-over version of the status quo where the insurers do things the way they were doing today.

You all have been very helpful. We have a vote on the floor. I think I can excuse us knowing we are going to call on you often in the days ahead. I thank you for all the valuable help you have given us.

[Whereupon, at 1:15 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

APPENDIX

MAJORITY MEMBERS

RON WYDEN, OREGON
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103d Congress

United States House of Representatives
Committee on Small Business
Subcommittee on Regulation,
Business Opportunities, and Technology
B-363 Rayburn House Office Building
Washington, DC 20515-6318

MINORITY MEMBERS

LARRY COMBEST, TEXAS
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JAY KIM, CALIFORNIA
PETER G. TORKIOSEN, MASSACHUSETTS
MICHAEL HUFFINGTON, CALIFORNIA

STEVE JENNING
SUBCOMMITTEE STAFF DIRECTOR
202-225-7797
FAX 202-225-4990

GRAYDON J. FORNER
SUBCOMMITTEE COUNSEL

ROBERT LEDMAN
MINORITY SUBCOMMITTEE PROFESSIONAL
202-225-4008

OPENING STATEMENT OF REP. RON WYDEN (D-OR)
CHAIRMAN, SMALL BUSINESS COMMITTEE
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND TECHNOLOGY

INFORMED CONSENT: THE ROLE OF CONSUMER CHOICE IN IMPROVING
THE QUALITY OF HEALTH CARE

JUNE 28, 1993

Today, the Subcommittee on Regulation, Business Opportunities and Technology will examine what will certainly be one of the bedrock issues in the debate over national health reform legislation: consumer choice. This is a make-or-break concern for the tens of thousands of small businesses and their employees and dependents on the eve of formal launching of the national health reform debate.

The freedom to choose one's medical providers will be a litmus test for any successful health reform plan proposed in this Congress. Making sure that America's first taste of health reform does not include the bitter flavor of Soviet-style barriers to free choice, is absolutely essential.

So far in this debate, every serious health care reform proposal has relied on the principle of informed consumers making cost-effective choices. Consumers will be asked to take more responsibility for the cost and quality of the health services they purchase. I support these goals. Whether the reformed health care market heals and comforts people -- or sucks them down into a sink hole of inaccessible, poor quality care -- will depend to a great extent on the quality of comparative information available to consumers, doctors, and purchasers.

No matter how elegant the new health care system is in its conception, it won't work if it's built on top of a rotten foundation of skimpy and fragmented information on cost and quality. At the very least, consumers have a right to know which health care providers they should avoid. Unfortunately, Americans today have more product performance information available to them when purchasing breakfast cereal than when choosing a heart surgeon.

Governmental barriers to informed choice, in particular, are everywhere in today's health care system. Today the Subcommittee will hear about two.

First, consumers are denied access to information in the Government's possession that would reveal whether the doctor treating them is one of the 7,000 doctors disciplined by a medical licensure board or hospital peer review committee in the United States during the past two years. This information is contained in the National Practitioners' Data Bank, but the consumer whose taxes are deposited in the Treasury to pay for the Data Bank are not allowed to withdraw information from it.

Second, the Subcommittee will hear testimony this morning that 37 States gather information on costs and quality, but only 3 of them will allow the public access to this information. In fact, the genesis of the landmark New York State report on Coronary Artery Surgery was a lawsuit won by Newsday, which had been denied access to this same information.

Federal health reform law should demolish these anticompetitive governmental barriers to well-informed consumer choice.

For example, there is no logical argument for denying the public the names of doctors who have paid multiple malpractice payments over a short period of time, or who have been sanctioned through hospital disciplinary actions or State licensure boards. As the principal sponsor of the legislation creating the data bank, I intend to push for enactment of a new law providing consumers with access to this essential information.

Opening the Data Bank will help consumers avoid some of the worst providers and repeat offenders that we will hear about from the first two witnesses this morning. But consumers need to know that quality of care is much more than the mere absence of documented gross or repeated negligence.

The Harvard Medical Practice studies show that only one in eight instances of negligence ever result in a malpractice suit being filed, much less won by the plaintiff. And plaintiffs win five times as many malpractice lawsuits as the number of instances in which negligence results in a license revocation or suspension of hospital privileges.

This means that additional measures of quality are needed. Consumers must have easy access to comparative information on plans, providers, and the success rates of the treatments they provide. This is no radical, futuristic concept. The last Congress passed, and President Bush signed, legislation I sponsored to publish infertility clinic pregnancy success rates, so consumers can choose which clinic, if any, to invest with their hopes and their cash.

Building on this precedent, this morning a coalition of over 30 national consumer groups will testify that they want a "report card" disclosing key quality measures, like the percentage of young children in a health plan who have received all appropriate immunizations, or the proportion of a cardiac surgeon's bypass patients who survive for a year. Consumers would use these report cards to decide which health plan to enroll in, and which providers to use when they need treatment.

Government is not the only source of barriers to informed choice. Today the Subcommittee will hear repeated accounts of Kafkaesque bureaucracies erected by managed care organizations as a barrier to prompt and appropriate treatment. Witnesses will testify this morning of Health Maintenance Organizations (HMOs) literally heaping insult on top of injury, first by providing unsatisfactory service, and then by refusing to pay for timely care that their desperate enrollees manage to find outside of the HMO.

The poor quality and cavalier behavior of some of these organizations is nourished and protected by their ability to lock in patients to using only the health plan's providers, even when those providers are unwilling or unable to do what's needed. By forcing consumers into entering into year-long contracts with these plans, the HMO is shifting risk to its enrollees, and letting consumers bear the burden.

There are alternatives. For example, there is the Point of Service HMO. These organizations allow consumers to use out of network non-HMO providers, recognizing that they may cost a little more to the consumer out-of-pocket.

The evidence shows that few patients in well-run Point of Service HMOs seek out of network services. Obviously, when consumers have this Point of Service option, plans must be responsive or lose control of their business. It is also worth noting that the Point of Service plans appear to be draw most of their subscribers from costly and inefficient indemnity health insurance plans. More importantly, this alternative shows that you can have real consumer choice and cost containment in peaceful coexistence.

The Chair believes that protecting the rights of consumers will have special benefits for small businesses. These health purchasers are hungry for comparative information on the quality of medical providers, so they will know who to contract with, and who to refer their employees to, for the best results. Small firms are telling this Subcommittee they are anxious to work with us on this important issue, and we intend to take them up on their offer.

LARRY COMBEST
10TH DISTRICT TEXAS

COMMITTEE ON AGRICULTURE
COMMITTEE ON SMALL BUSINESS
PERMANENT SELECT COMMITTEE
ON INTELLIGENCE

Room 1511
LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON DC 20515-4319
(202) 225-4005

Congress of the United States House of Representatives

OPENING STATEMENT OF
HONORABLE LARRY COMBEST
COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND TECHNOLOGY
INFORMED CONSENT: THE ROLE OF CONSUMER CHOICE IN IMPROVING
THE QUALITY OF HEALTH CARE

JUNE 28, 1993

Mr. Chairman, I would like to thank you for calling this hearing on what I feel are some of the most complex and controversial issues that we must confront in trying to reform the nation's health care system. We all agree that "bad doctors" do exist and I think we all agree that immediate steps have to be taken to ensure that tragedies like the ones we will hear this morning are not duplicated.

I know that some here today, including the Chairman, advocate allowing consumers to have unparalleled access to information on health care providers. I certainly would agree that as part of the overall effort to reform the health care system a better informed consumer will be essential to ensure higher quality care while keeping health care inflation down. But, Mr. Chairman like so many problems that we deal with in Congress, the problems are so much easier to identify than the possible solutions.

As the Congressional leader in establishing the National Practitioner Data Bank, I believe that you are keenly aware of both its strengths and weaknesses. As I understand it, the Data Bank has been collecting and maintaining data on medical liability claims and adverse actions taken against health care professionals since September, 1990. While only doctors who have had settlements for malpractice claims are listed on the data bank, the fact that a settlement has occurred may have little relation to whether there actually was negligence.

In this hyper-litigated society, the typical physician has a 38 percent chance of being sued for medical malpractice and, if they practice surgery, this increases to over 50 percent. The average OB/GYN can expect to be sued at least three times during his career.

Currently the information on the Data Bank can only be accessed by hospitals and accrediting medical boards that have the ability to sanction physicians. While I believe efforts to increase access to health care information for consumers is important, we must work to ensure that we do not further alienate the medical

DISTRICT OFFICES

Room 813
FEDERAL BUILDING
LUBBOCK, TX 79401
(806) 763-1811

Suite 205
3800 E. 42nd Street
Oklahoma City, OK 73109
(915) 362-2637

Suite 205
5809 S. Westman
Amarillo, TX 79110
(806) 353-3545

Suite 114
511 W. O-0
Midland, TX 79701
(915) 687-0926

community. At a time when many physicians feel that the federal government is overly micro-managing their occupation, it is essential that policy makers work hand-in-hand with doctors. If not, I believe comprehensive health care reform will not be possible.

Mr. Chairman, in closing, let me thank you for your efforts in the health care reform debate, I look forward to finding some solutions to the many difficult problems presented before this subcommittee.

Opening Statement of the Honorable James H. Billray
6/28/93
Subcommittee on Regulation, Business Opportunities and Technology
Committee on Small Business

I appreciate the Chairman's foresight by calling this very important hearing as the health care reform debate looms before the Congress.

As bits and pieces of the upcoming health care package have filtered out, no more important question has been continuously asked by the American public; will Americans be able to make an informed choice when choosing a doctor. As it stands right now, state and federal quality systems have failed to protect consumers from doctors with long track records of negligence. In addition, the government has failed to put in place a system to provide consumers with comprehensive comparative data on doctors track records, comparisons of insurance plans and its participating doctors and hospitals.

If there is one aspect of health reform that no one will argue about is the need to provide consumers with quality information so that they may be able to make informed choices for themselves and their families. No health care reform proposal will be successful unless it achieves at least that.

I look forward to today's witnesses and their recommendations as to how we can not only provide this information but also fix the somewhat limiting structure of today's health plans. It is my hope that Mrs. Clinton has also listened to voices such as these and that her plan will reflect the desires and the best interest of the American people.

**TESTIMONY OF AVIS AND MARK BENNETT
BEFORE
THE SMALL BUSINESS SUBCOMMITTEE ON REGULATION,
BUSINESS OPPORTUNITIES AND TECHNOLOGY
JUNE 28, 1993**

Good morning, my name is Avis Bennett. This is my husband Mark. We reside at 44 Summer Street in Dover New Hampshire. We are grateful for the opportunity to join you today to share our personal story about the devastating consequences that can result from being denied the ability to make an informed choice about a medical practitioner.

We became involved in this issue because of events that happened in 1984. That was the year my husband, I and our three children moved to Dover New Hampshire, a small eastern seacoast community. Our daughter Heather, who was three and a half years old at the time, had been born with a large cyst in her brain. The cyst had only allowed one quarter of Heather's brain to develop. The doctors inserted a shunt, which is a devise placed in the skull to allow excess fluid to drain down from the cyst through a tube. The tube would carry the fluid away from her brain, down her neck, over her chest and into her stomach cavity where it was absorbed.

Heather's prognosis was grim. We were told that in all likelihood she be severely retarded and that we should consider institutionalizing her. But Heather was our miracle child. She grew up achieving all the normal milestones.

When we moved to New Hampshire, we were elated to discover that there was a neurosurgeon only minutes from our home. Dr. Stephen O. Dell had been referred to us by Wentworth-Douglass Hospital in Dover as well as by our previous neurosurgeon who had looked the doctor up in the Physicians Directory.

Although Heather was doing beautifully, having no trouble with the shunt, we knew she needed to be under a neurosurgeon's care for periodic checkups. We were also aware that as Heather grew, the tubing that had been coiled in her stomach would shorten and eventually need to be replaced with longer tubing. Her former doctor estimated that she would probably need that procedure done at about 4 years old.

We scheduled our first visit with Dr. Dell in May of 1984. He was very impressed with Heather's progress, as was I with Dr. Dell's credentials. His office walls were lined with certificates from a number of very prestigious universities, and he told me that he had just been accepted into a pediatric neurological society. I also noticed from the sign outside his door, that he had both an M.D. and a Ph.D.

(2)

During that first exam we discussed the shunt lengthening procedure. He told us that Heather should have the procedure done now. He described it as a very simple operation that would be done as a day surgery. He explained that he would only be reopening the incision in Heather's stomach to place the additional tubing.

When I asked Dr. Dell if he had done this procedure before he laughed and said he had done this surgery more times than my "country" doctor in Vermont would ever see. I took his response as an definitive "yes", knowing that my doctor in Vermont had taken care of many pediatric shunts.

When I asked about the risks of doing the procedure he told me that there was a 99.9% chance of no problems. The only potential risk he saw was a fatal reaction to the anesthesia. I was not alarmed by that because Heather had received anesthesia as a baby and tolerated it well. And we had provided Dr. Dell with all of those records to review.

Dr. Dell had answered all my questions and I felt very confident about going through with the surgery and comfortable with him as Heather's physician.

On July 9th at 6 a.m. Heather, my husband and I arrived at Wentworth-Douglass Hospital. Heather's was the first surgery scheduled. They wheeled her into the operating room at 8 a.m. At 10:30, Dr. Dell finally came out to the waiting room to assure us that all had gone well. At that point, he introduced us to a Dr. Prostkoff, who he explained had assisted him with Heather's surgery. We were told that Heather would be out of recovery soon and I could wait for her in her hospital room.

Since all had apparently gone well, my husband and I decided that I would spend the afternoon with Heather and he would go home to be with our two boys.

When Heather first got back to her room she was doing great. She was alert and awake, busily describing the bubble gum anesthesia she had been given. About 40 minutes later, however, she began to vomit. As the afternoon wore on, Heather complained of headaches and slept between her hourly episodes of vomiting.

Dr. Prostkoff, the "assistant" surgeon, checked in on Heather that afternoon, but only to monitor her bowel sounds. He never checked her neurological vital signs. By late afternoon, which was when Heather was supposed to be released, Dr. Dell phoned and recommended that she stay at the hospital overnight. He assured me that Heather was just having a reaction to the anesthesia, which is common in children, and said she would be fine by morning.

(3)

My husband decided to come back to the hospital to relieve me for awhile. As I was waiting for him, I remember thinking "these are all signs of a blocked shunt". There is a small valve located at the back of the shunt to help drain the fluid if there is a problem, but it is only to be pushed in an emergency. I was about to push it, but unfortunately stopped myself at the last moment thinking that I was surrounded by medical professionals and two neurosurgeons who would surely recognize if Heather was having a real problem, and take the appropriate steps.

So when my husband arrived I reassured him, as Dr. Dell had reassured me that Heather was just having a reaction to the anesthesia but would be fine by morning.

But Heather's condition continued to deteriorate. By evening the nurses and my husband were very concerned. The nurses made numerous attempts to contact Dr. Dell and alert him about Heather's condition. Finally, at 10:30 that night Dr. Dell arrived at the hospital. But instead of doing a neurological exam, he only checked her incision and assured my husband that there was nothing to worry about. He said Heather would be her old self in the morning. My husband noticed a scratch on Heather's head, and asked Dr. Dell if he had done anything to her head during the surgery. Dr. Dell briefly looked at the scratch and simply restated that Heather would be fine.

At midnight, as my husband was laying his head down by Heather, he noticed bubbles coming out of her mouth. Heather had gone into respiratory arrest. An emergency team was called in and revived her, but as they were reviving her she began to vomit, breathing it into her lungs, causing a severe case of aspirated pneumonia.

We were told that when Dr. Dell arrived in the Intensive Care Unit, he cut Heather open without anesthesia, pulled out her tubing and cerebral fluid which had been trapped by the blockage, sprayed all across the room.

Judging by the expressions on the faces of the staff in the Intensive Care unit, we knew our little girl was gravely ill, yet Dr. Dell continued to be very optimistic. We knew that this situation should never have happened and my husband and I began thinking about transferring Heather to another facility. But we were told that she could not be moved until her condition stabilized. From that point on, Heather's condition only worsened. By morning she began having seizures. They became so severe that her entire body would shake uncontrollably, her eyes would roll back and she was drooling from the sides of her mouth.

(4)

A neurologist was finally called in to administer seizure medication. Between doses, as a nurse was washing Heather she lifted up Heather's head and she went into cardiac arrest. We believe that Heather's badly damaged brain stem had snapped. They worked on her for two hours to try to revive her, but this time they couldn't bring her back.

I brought in a beautiful healthy little girl who had overcome so many obstacles, who was ready to lead a normal life, who we loved with all our heart, and a little more than 24 hours after placing her into Dr. Dell's hands she was dead. When I asked Dr. Dell how something like this could happen, he responded by saying it wasn't his fault, and claimed the nurses never told him about her symptoms.

That would be only the first of many lies in which Dr. Dell was caught. Heather's records had clear documentation of the many calls made to him by the nursing staff, describing her symptoms. In fact, as a result of one of those calls, he prescribed tylenol for Heather's headaches.

When the evening nurse was deposed, she stated that she followed Dr. Dell out of Heather's room, down the hall, and over to another ward to question him about the possibility of intracranial pressure due to a blockage. Instead of listening to her concerns, however, Dr. Dell's response was "leave me alone, I'm the doctor".

After Heather's death we uncovered many problems with Dr. Dell's background, skill, experience and moral character. We learned that despite his claim about having experience with pediatric shunts, he had never done that procedure before at Wentworth-Douglass, and we could find no evidence that he had ever performed this procedure in the four years prior when he worked at the Veteran's Hospital in Boston.

We also learned that the physician Dr. Dell introduced as the "assistant" surgeon, had, in fact, never assisted with Heather's surgery. When Dr. Prescoff was deposed, he stated that he was not in the O.R. that day and that he had not dressed or scrubbed for the surgery.

Wentworth Hospital required that there be an assistant present during all surgeries. Rather than adhering to that policy, however, Dr. Dell chose to simply write the doctor's name in Heather's chart, and introduce him as the assistant.

We were also stunned to learn that Heather never needed the surgery at that time. In fact, the tubing ended up being shorter AFTER Dr. Dell's surgery.

(5)

When Heather's anesthesiologist was deposed, he stated that she had been under anesthesia for 40 minutes before Dr. Dell finally arrived. He also said that if Dr. Dell had taken the time to call him, he would have told him that the vomiting was not a reaction to the anesthesia, or she would have begun vomiting immediately following surgery.

We also uncovered the fact that Dr. Dell had lied about many of his credentials. He never received a Ph.D from Princeton, as he claimed. He was never awarded a degree from Oxford, as he claimed. And he never received a degree in Mathematics from Harvard, as he claimed.

In the years since Heather's death we have learned so much about Dr. Dell both as a physician and as human being, and it horrifies us that he is still out there practicing. Much of the blame, however, can be traced back to the profession itself and the physician oversight systems which have enabled dangerous doctors like Stephen Dell to continue harming and killing innocent patients.

Dr. Dell holds licenses in seven states: New Hampshire, New York, California, New Jersey, Vermont, Maine and Massachusetts. And his medical offenses can be traced to the beginning of his practice:

Although he came to Wentworth-Douglass Hospital in 1982 with glowing recommendations from the Tufts New England Medical Center in Boston, (where he had worked from 1978-1982), Wentworth-Douglass Hospital later learned that Dr. Dell had, in reality, been forced to leave Tufts. He was found to have been an inadequate technician both in terms of diagnosis and surgical skill, he had problems with interpersonal relationships, and he had an unacceptable level of morbidity for certain procedures he performed.

Dr. Dell also had problems at Wentworth Hospital during his entire tenure (from 1982 to 1988). In 1988, prompted by our attorney's discovery about the lies on Dr. Dell's Curriculum Vitae, Wentworth finally suspended his privileges. In doing so they sighted that he was flagrantly insensitive, careless and dishonest. He had poor relationships with several departments. He repeatedly failed to provide coverage for his patients when he was away for the weekend. He falsified documents. He lied to his patients, and was found to have been responsible for the poor outcomes of 15 patients, including 3 patient deaths. (He has also been sued at least nine times for medical malpractice.)

Dr. Dell then filed a lawsuit against the hospital. And in 1989 an agreement was reached whereby Dr. Dell would be reinstated and allowed to permanently resign his privileges.

(6)

Based on the action taken by Wentworth-Douglass Hospital, the New Hampshire Board of Medicine initiated an investigation of Dr. Dell. But instead of charging him with misconduct based on the incompetent and negligent treatment of his patients, as outlined in the Wentworth-Douglas report, they entered into a consent agreement in 1990. The agreement only required Dr. Dell to admit that he lied about his credentials, and lied to a patient about having performed surgery on the wrong disc.

According to the attorney for the Medical Board, a verbal agreement had been reached between Dr. Dell and the Board stipulating that he would no longer practice in New Hampshire (although the Board did not revoke his license). Dr. Dell had convinced the Board that he wanted to move to Texas but would be unable to if the misconduct charges in New Hampshire were too severe.

So, New Hampshire merely reprimanded him and required that he complete a medical ethics course and formally acknowledge to the hospital and a patient that he had lied, before renewing his license. New Hampshire expected Dr. Dell to become some other state's problem, but the plan backfired.

Thanks in part to our efforts, Dr. Dell was unable to get a license in Texas, and returned to New Hampshire seeking to reinstate his license. The state has reopened his case, and is finally looking at the pattern of patient harm.

In the meantime, in late 1990, Dr. Dell went to New York and was granted temporary privileges at Brookdale Hospital. In February 1991, however, Brookdale terminated his temporary privileges and refused to grant him permanent privileges because of the "nature" of Dr. Dell's practice, including his pre-operative evaluation of patient needs, surgical performance and post-operative care of patients.

In 1992, the Vermont State Medical Board disciplined Dr. Dell based on the New Hampshire action and for lying on his license application in Vermont. Although the action they took was very lenient, it was stipulated that he could not resume practice in the state until the New Hampshire case was resolved.

New York's Medical Board is also in the process of disciplining Dr. Dell based on both the New Hampshire and Vermont actions.

New Jersey and Maine have not yet moved on Dr. Dell, because he is currently not registered to practice in those states.

Although Massachusetts was aware of the actions against Dr. Dell, they just recently allowed him to renew his registration to practice medicine in that state. And even though he been unable to get hospital privileges, it has not slowed him down.

(7)

He has already set-up five private clinics across Massachusetts and is currently working there. It is conceivable that because he holds licenses in so many states, it might take years before he is finally stopped from practicing.

Nothing will ever bring Heather back, but if someone had spoken up about Dr. Dell beforehand, our daughter might be alive today. Our family lives with the pain of losing Heather every day. It is a pain we do not wish on any parent. Medical consumers MUST be allowed to have access to the National Practitioners Data Bank in order to make truly informed decisions about their medical care. This is not an issue of revenge, it is an issue of public protection.

The public has a right to know about Dr. Dell's pattern of dangerous, unprofessional and unethical care. And our tragic experience has shown us that we cannot rely on a hospital, or oversight agency to protect us from harm.

TESTIMONY OF MARY AND TOM MILLER
BEFORE
THE SMALL BUSINESS SUBCOMMITTEE ON REGULATION,
BUSINESS OPPORTUNITIES AND TECHNOLOGY
JUNE 28, 1993

Good morning. I am Mary Miller and this is my husband Tom. We are from Putnam County, Connecticut. Thank you for the opportunity to speak before the Subcommittee today on an issue which has touched our lives and which we feel very strongly about. Namely, the need for consumer access to information about doctors performance records.

In December of 1991, I made an appointment with Dr. Steven Ira Weber. Dr. Weber had only just moved into the area and had taken over my former physician's private practice. I developed what appeared to be a yeast or urinary tract infection which I wanted to have checked out. Dr. Weber was anxious to meet his new patients and I noticed that he had kept on my former doctors office staff. That made for a more comfortable transition from one doctor to the other.

He treated my immediate problem and scheduled a follow up in-office visit for a complete checkup and review of my medical history. My medical history included surgeries for ruptured ovarian cysts. I'd also had surgeries to clear my fallopian tubes to enhance my chances of becoming pregnant because I had been having difficulty conceiving.

During that next visit, Dr. Weber found cervical polyps. An in-office appointment was made to remove them and biopsy some tissue from my endometrium to help determine why I was growing polyps. The following week I received a call from his office stating that there was a problem with the biopsy and they needed to do a blood workup on me.

When I came in to have the blood drawn, I asked if there was anything more they could tell me. The nurse said the doctor would be in to talk to me, but when he arrived, all he would volunteer was that my estrogen levels seemed high and the blood work was just routine.

The next day, his office called again. This time they wanted me to come in so that Dr. Weber could remove additional tissue from my endometrium which they claimed they had not completely removed during that first procedure. This request was not urgent, but they did indicate that sooner was better than later. When I asked his nurse if there was anything I should be worried about, she said that the doctor would explain everything and that there was nothing to fear. But I was afraid that they had found something in the biopsy they weren't telling me about, so I scheduled the appointment for that afternoon.

That in-office procedure was done on Friday, January 17, 1992, which was the last time I saw Dr. Weber as a patient.

On the following day, Saturday, I began bleeding vaginally and became alarmed. My husband took me to the emergency room of our local hospital, Day Kimball Hospital in Putnam. Dr. Weber's service was called but they said he was off for the weekend. So I was seen by the E.R. physician who was a visiting fellow from Yale-New Haven Hospital in New Haven Connecticut.

Blood work at the E.R. revealed that I was pregnant and in danger of losing the pregnancy. They allowed me to return home but scheduled a follow up visit for noon the next day to have an ultrasound to determine if the pregnancy was still intact.

I was in shock. My husband and I began asking ourselves if there was any way Dr. Weber could have known about the pregnancy, and if he did, why hadn't we been told. The ultrasound confirmed that the pregnancy was lost and we were told that the procedure Dr. Weber did in his office that Friday could have been the cause.

At that point, I requested all my records from Day Kimball Hospital as well as the records from Weber's office in an attempt to piece together the events that had just taken place.

Dr. Weber became uncooperative, delaying access to lab test results and also told us that he had known about the pregnancy but didn't tell me because he didn't feel the pregnancy was viable. Only after we gotten hold of all the records, did the horror of what really happened begin to sink in.

Dr. Weber had not ordered a pregnancy test during my initial examination. He believed, as we believed, based on my medical history, that I could not have been pregnant.

It turned out that the polyps he removed revealed nothing unusual, but the "endometrial" tissue he had biopsied revealed "products of conception". The blood work he ordered on me was not to diagnose or evaluate my estrogen levels, but was actually a pregnancy test to confirm the pathological findings. The second surgical procedure he did that Friday, which he called a mini D & C, was in fact done to remove the last remaining traces of the embryo from the uterus. But, he had obviously not done a good job at that either.

This started a long trail of discovery for me and my husband, and what we found out about Dr. Weber was truly horrifying. Based on my incident, Day Kimball Hospital withdrew Dr. Weber's privileges and reported him to the Connecticut Board of Medical Examiners. The Board then issued a summary suspension against his license. An attorney from the Board contacted us to ask if we would be willing to testify at a Dr. Weber's disciplinary hearing.

Upon meeting with the Board's attorney, we learned that in 1990, Dr. Weber had lost his license to practice in New York based on numerous instances of gross negligence, incompetence and patient abuse.

Some of the charges Weber was found guilty of include:

- o Waiting three hours before calling an ambulance for a woman whose womb he had accidentally punctured during a routine abortion in his office. The woman lost her uterus and nearly died.
- o Using 10 to 20 times the standard dose of a labor-inducing drug that, when overused, can cause a woman to die of heart failure.
- o Misreading the fetal warning signs that a woman in labor needed a caesarean section. The baby died.
- o Slapping the face of a patient in labor.
- o Failing to detect signs of gestational diabetes, and misreading the seriousness of the fetal stress test during that patient's labor. The baby died in the womb.
- o Improper use of forceps and falling on a patient during delivery. The baby was born alive, but with a cut over the right eye, and a blood cyst on the scalp.

When we asked the Board's attorney how Connecticut could have allowed a doctor who had been found guilty of such atrocities to obtain a Connecticut license, we were told that Dr. Weber was already licensed in Connecticut at the time his New York license was revoked. In fact, during the time he was in private practice in New York he was also working weekends and in his spare time at a family planning clinic in Danbury, CT., performing abortions.

Since Connecticut had no record of complaints against him, his license was not revoked despite the New York action. But Weber's attorney did concede, based on the New York action, that there were obvious gaps in Weber's medical training, so Connecticut placed him on probation.

Part of his agreement, required that he be supervised when in a hospital setting, and that the hospital submit quarterly progress reports to the Board. This stipulation, however, left me and all his other office patients totally vulnerable, because there was nobody to supervise him when he did procedures in the privacy of his own office.

At Weber's disciplinary hearing, the Chief of Staff at Day Kimball Hospital testified that when he confronted Weber about what he had done to me, Weber responding by saying that "there is more liability in a damaged fetus than an aborted one". And during a subsequent conversation with the Head of the OB/GYN Department at Day Kimball, Weber dismissed what he had done to me by saying, "I've done 10,000 abortions. What's one more?".

We also learned that Weber had received his medical training in Mexico, at a school investigated for the ease with which one could enter and graduate, but which failed to meet the barest requirements for a medical education.

No one ever came forward with any of this information. Not the staff in his office who I knew for years, prior to Weber's taking over the practice. Not Day Kimball Hospital where we were known personally and professionally by several people. We did not know about his substandard medical education or his prior problems in another state.

When we asked questions pertinent to my health and well-being we were lied to. The hospital had access to information on him through the National Practitioners Data Bank (his license was revoked September 24th, 1990) yet, they decided to give him the benefit of the doubt and allowed him to practice in our community. We had no information available to us to make an informed decision about my health. And because of the lies he told, we were never given the opportunity to get a second opinion, or give informed consent for the procedures he did.

Six months ago, our first child was born, so we feel very fortunate. But at the time I lost the pregnancy, I had no idea if I could ever become pregnant again. And even though we do feel blessed, we think about that little person who will never be in our lives, and the cruel and inhuman treatment that prevented him or her from being born. And even though Connecticut finally did revoke his license, it does not excuse the fact that innocent lives were placed at risk because of their initial failure to take aggressive action against him.

If we had been able to access the National Practitioners Data Bank, we would have seen that this was not a doctor who made one or two mistakes in a lifelong career, but a relatively young doctor who made a number of his patients suffer devastating harm and losses, and whose medical license was revoked in another state. There is no question that we would have stayed away.

Mary and Tom Miller
533 Church Street
Putnam County, Connecticut 06260

TESTIMONY
OF
JOSEFINA PEREZ

HEARING ON CONSUMER CHOICE AND QUALITY OF HEALTH CARE

JUNE 28, 1993

1. My name is Josefina Perez. I live in Homestead, Florida. I am a single, working parent.

2. I am a Medicaid recipient, with four minor children.

3. We were enrolled in the Community Medical Plan HMO.

4. During the evening of September 24, 1992, I went to the emergency room at South Miami Hospital in Homestead because I was bleeding and having contractions. I had not had a period in three months and assumed I was pregnant. I had had two positive pregnancy tests. The HMO was closed at that time. On September 29, 1992, I did miscarry. This was confirmed by the gynecologist I saw later that day who reviewed my earlier bloodtest and did an ultrasound.

5. The HMO is now refusing to pay the bill from the emergency room.

6. In December, 1992, I took one of my daughters to the emergency room because she had had a fever for three days and when the fever broke her mouth was full of bleeding sores. She was bleeding so badly from her mouth that she had been able to drink or eat very little for the past few days. Again it was in the evening and the HMO was closed.

7. Before taking my daughter to the emergency room, I had called the HMO during the day and was told the doctor was on vacation and that I should go to the emergency room.

8. The emergency room registrar called the HMO for approval and was told that this was not an emergency and my daughter could not be seen. The hospital registrar told me to call the HMO to see if I could reason with them. I called the HMO and asked to speak with the "approver" and the answering service said I was not allowed to do so, that only hospitals and HRS are allowed to speak to the "approvers", not the client. I asked the answering service operator if she could deliver the approver a message to see if my daughter could be treated at the emergency room because she had been bleeding badly from her mouth and was unable to eat or drink with all the blood. She said I would have to wait until Monday when her regular doctor came in. I protested that she would have to wait three more days and was not able to eat or drink and the HMO still refused to let her be seen.

9. The hospital called the HMO back because they saw my

daughter was in pain and the HMO still refused to treat her. The hospital told me I would have to give them money up front which I did not have.

10. I called the HMO back and asked the operator for her name. She told me it was "none of my damn business" and hung up on me.

11. I went home and treated my daughter myself with medicine which my son had been taking. He then ended up getting sick again.

12. On the following Monday I called the HMO and told them what happened the previous Friday evening and I was told they would "Take care of it." I also told them I wanted to disenroll from the HMO and the HMO insisted this would not happen again.

13. I also told them they had not been paying the bill for my emergency room treatment in September because I was getting the bills. The HMO denied the fact that they were not paying the bills. They told me to photocopy the bills and send them to them. I did so and the bills have still not been paid.

14. In December I called the number on the back of the card regarding complaints. The lady that answered the phone told me that she could not speak to me and that I should talk to my HRS worker. She hung up on me.

15. I called the HMO again to speak with a supervisor about my problems and was told that the reason the hospital bill will not be paid was that the hospital did not seek approval from the HMO before I was seen so I had to pay the bill.

16. I also have a daughter who had chronic ear infections for six months. She finally received approval to be seen by a specialist. However, the specialist's office is in Hallendale. I live in Homestead, which is over an hour and one-half away. Since I do not know my way around that area I called the HMO for their van service and stayed home from work a half day in order to wait for the van. The van never came.

17. When I asked for a new appointment with the specialist since the van never came, I was told that I would not get another approval since I missed the first appointment with the specialist.

18. In April, one of my daughters fell and injured her face. I called the HMO and was told that her doctor was on vacation. I asked if I could take her to the emergency room and was told "no". The HMO receptionist said she would call back with the name of another doctor but she never did. I continued calling a number of times but the HMO never called back with a referral. My daughter's face was badly swollen and she had trouble breathing. She was unable to go to school and I had to miss work in order to stay home with her.

19. Around the same time another daughter got an ear infection. Again, I was told her doctor was on vacation so I asked for another doctor. The HMO receptionist said she would call back. I called back 2 times, left the same message, waited at home all day and never received a call back.

20. After the doctor came back from vacation, I called him again and he told me that she would need an appointment to see him, and that since no appointments were available for awhile, she should go to the emergency room. I took my daughter to the emergency room for treatment. The emergency room is now billing me for her treatment.

21. I began trying to get disenrolled from the HMO in February and was not disenrolled until May.

SUBSCRIBED AND SWORN TO under the pain and penalty of perjury this 6/25/93 day of June, 1993.

JOSEFINA PEREZ, Affiant

Yale University

SCHOOL OF MEDICINE
333 Cedar Street
P.O. Box 3333
New Haven, Connecticut 06510
(203) 785-6938
(203) 785-3024 FAX



ROBERT I. WHITE, JR., M.D.
Professor and Chairman
Department of Diagnostic Radiology

TESTIMONY

House of Representatives
SubCommittee on Regulation, Business Opportunities and Technology
Hearing on Freedom of Choice and Quality of Health Care
Chairman, Ron Wyden
June 28, 1993

ACCESS TO EXPERT HEALTH CARE FOR PERSONS WITH RARE DISORDERS

Thank you for the opportunity to speak with you about patients with rare disorders who have difficulty getting appropriate care through their HMOs. Rare disorders are not so rare, when you consider that one person in twelve has a condition which may require specialized care.

OVERVIEW FROM PERSPECTIVE OF PATIENT NEEDS

My name is Robert I. White, Jr, and I am an interventional radiologist; that is, I perform image guided procedures without surgery -- euphemistically known as "surgery without a knife". As such, our patients spend, on average, 24 to 48 hours in the hospital, and have no significant post procedure recovery. I am also the Chairman of Diagnostic Radiology at Yale University School of Medicine and Chief of the Section of Diagnostic Imaging, Yale-New Haven Hospital and Chair of the Medical Advisory Board of HHT Foundation International, Inc. Hereditary Hemorrhagic Telangiectasia (HHT) is a rare disorder of blood vessels effecting the nose, brain, lung and intestine. In a typical week, we will spend between five and ten hours in frustrating negotiations with HMOs and other managed care providers trying to help our patients through the system.

The following short patient presentations are illustrative of the frustrations shared by the patients and ourselves dealing with the HMOs.

C.K. is a 45 year old Palo Alto, CA teacher who has HHT. Her HMO refused to let her be treated at Yale-New Haven Hospital. Today she is requiring blood transfusions for an anemia secondary to gastrointestinal bleeding which is a result of her disease. She is afraid to appeal to her HMO because she is concerned she will lose coverage.

continued

L. M. is a 50 year old Hartford, CT man with a 3 year history of allergic reactions to iron infusions. He has refractory nosebleeds (epistaxis) which last anywhere from 2 to 3 hours; gastrointestinal bleeding, anemia and angina pectoris.

For the past 3 years he has been followed by a Hartford HMO. He came to us for an evaluation at Yale after a great many frustrating delays by his HMO. In addition to diagnosis and treatment of gastrointestinal bleeding, he needed a specialized nasal operation, which is not available in New Haven or Hartford. We treated him for his intestinal bleeding and finally convinced the HMO that they needed to send him to Boston for nasal surgery. We had to threaten the medical director of the HMO with a lawsuit if the patient's care was less than optimal before the patient was permitted to go to Boston for the nasal operation.

A.R. is a 58 year old woman with brain abscess and a large PAVM -- pulmonary arteriovenous malformation, this is a malformation of the arteries and veins which can cause stroke, brain abscesses and excessive bleeding within the lungs. She was followed in Boston by a prominent physician at a well-known HMO. They recommended surgical removal of the lung. This would have been a difficult operation costing 2-3 times the less invasive alternative. The patient's son learned of HHT and the non-invasive therapy we use at Yale for treating pulmonary malformations (a technique that I developed which is similar in complexity to coronary balloon angioplasty, but instead blocks the abnormal blood vessel of the lung and takes twice as long to perform). The patient came to Yale after many hours of negotiations with the HMO. We treated her with the non-invasive balloon procedure. She did not require surgery. There was no post operative recovery. She was discharged within 48 hours and is doing very well.

B. C., a 62 year old woman with HHT, was to come to Yale for treatment. Before we could do the balloon procedure, we needed a specific study, a measure of blood oxygen in room air and after breathing 100% oxygen. The HMO insisted that they would do the initial procedure themselves in their own facility to reduce her care cost.

Our clinical nurse coordinator, Catherine Burdge, explained to the HMO that it was very important that the measure of blood gases be done at Yale-New Haven Hospital because we have the special equipment and expertise needed to perform it, as well as the physicians who are experienced in the technique. The HMO refused.

When the patient arrived at Yale, it was apparent from the report that the study had been done incorrectly. It had to be repeated, and caused additional anxiety and expense for the patient.

The real problems with HMOs trying to treat rare disorders are that they often lack experience and physicians who have expertise in specialized techniques needed for diagnosis and treatment of rare disorders.

continued

OVERVIEW OF RARE DISEASES AND PATIENT NEEDS

*There are 5,000 rare disorders affecting 20 million Americans. This means that one in twelve of us has a condition that may require special care. A rare disease is defined as 200,000 or less affected individuals. Examples include: Tourette's Syndrome, (which the Child Psychiatrists treat at Yale), Autism, Huntington's disorder, Cleft palate, Spina bifida, Lou Gehrig's Disease, and the one I'm interested in which is HHT.

*There are centers of excellence for treating rare disorders in this country; which are defined as a health care facility with a concentration of physicians and nurses seeing minimally 30-40 patients yearly with the disorder and with proven expertise as demonstrated by articles published in peer reviewed journals.

*Physician-specialists at centers of excellence with an interest in the specific rare disease which they study and treat, will often lower their own fees and lobby for the hospital to do the same in order to make specialized treatment affordable and available.

*The National Organization of Rare Diseases (NORD) is a highly effective advocacy group comprising a coalition of non-profit organizations representing rare disorders.

RECOMMENDATIONS

1. Freedom of choice for patients with a rare disorder; that is, the ability to seek diagnosis and treatment in a center with specialized expertise for managing their condition.
2. Point of service option -- by that we mean the patient with a rare disorder can seek an alternate care provider without undue penalties such as financial loss or other penalties such as loss of insurance.
3. Ombudsman for rare disorder so patient/physician are provided with choices.
4. Managed competition and cost to be facilitated by a simple type of agreement so that patients do not lose treatment options or delay in diagnosis during lengthy negotiations between insurance companies, hospitals, HMOs, physicians and employers.
5. Routine referrals by HMO's and managed care practitioners to centers of excellence for rare disorders, as defined by Jesse G. Thoene, MD in The Physicians' Guide to Rare Diseases, Dowden Press, Montvale, NJ 1992.

HHT Foundation International, Inc.

(Osler-Weber-Rendu)

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SUMMARY FOR JULY 92 MEETING HHT FOUNDATION INTERNATIONAL, INC.

INTRODUCTION

As a result of planning for the first HHT Foundation International, Inc. meeting July 25 - 26, 1992, it was decided to write an updated summary of some of the features associated with this disorder. Hereditary Hemorrhagic Telangiectasia (HHT) and its other well known name, Osler-Weber-Rendu Disease (OWR), was first described in 1896 by Professor Rendu, a French internist. Some of you know it as Osler's Disease after Sir William Osler who was a famous Canadian and American internist; he described the familial association of HHT while he was a senior professor of medicine at Johns Hopkins Hospital in 1901. The other physician whose name is associated with this syndrome is Professor Weber, a dermatologist who practiced and lived in England and was responsible for describing in detail the dermatologic manifestations of this syndrome.

Progress in understanding and treating HHT is occurring more rapidly now than in previous decades. It is highly likely before the end of the 20th century that the chromosome, and possibly the gene, for HHT will be localized thus enabling families to obtain genetic confirmation through a blood test.

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HHT affects primarily four organ systems. These include the brain, lung, nose, and gastrointestinal system. HHT is not a disorder of blood clotting or clotting factors within the blood, but instead is a disorder of the small and medium sized arteries of the body. The arteries either have abnormal structure leading to increased fragility (bleeding and aneurysm "bubble" formation) or abnormal direct connection with veins (arteriovenous malformation). The diagnosis of HHT is often overlooked since symptoms may be relatively mild. In some families, HHT can be lethal and it is estimated that the mortality from complications associated with HHT is approximately 10%. Fortunately, deaths attributable to HHT can, in most instances, be prevented by screening and treatment for this disorder. Furthermore, many disabling symptoms may be treated effectively and it is likely that within the next decade additional new treatments will be perfected.

GENETICS

HHT is considered an autosomal dominant disorder meaning that 50% of children of a mother or father with HHT will be affected. The other children will not be affected nor will they pass the gene on to their children. Most large university medical centers have genetic counseling available and additional information about HHT can be obtained from HHT Foundation International, Inc.

NOSE:

Nosebleeds (epistaxis) occur in 90% of patients. In 50% of patients, nosebleeds first appear before adolescence and 90% of patients will have recurrent nosebleeds start before age 21. Symptoms may be mild or so severe that patients may experience daily nosebleeds lasting 30-60 minutes. In general, nosebleeds will become more severe with age, although some patients experience a remission in later life.

In addition to humidification and nasal moisteners, many therapies have been developed to aid in controlling hemorrhage. Iron supplements are often required to keep the blood count in a more normal range. Some patients require blood transfusions.

Palliation for recurrent nosebleeds can be achieved by septal dermoplasty, a surgical procedure, which involves placing skin grafts in the inner nose. This procedure may have to be repeated every five- to ten years to obtain satisfactory palliation. Different forms of laser application to the inner lining (mucosa) of the nose have also been used successfully to palliate nosebleeds. Radiologic techniques including blocking the arteries to the nose with plastic particles have been used to provide relief in patients with severe nosebleeds. Finally, combinations of estrogen or progesterone and anabolic steroids have been used successfully in maintenance form to reduce bleeding. All of these therapies will be successful in some patients. It is anticipated that over the course of the next ten years, comparative trials of these different forms of management will be conducted leading to an improved decision tree for treatment of nosebleeds.

LUNG:

Pulmonary arteriovenous malformations (PAVMs): represent direct connections between the arteries and veins in the lung. Approximately 15- to 20% of patients with HHT may be affected by PAVMs. When multiple or when PAVMs affect the lung diffusely, patients may be symptomatic very early in life. The lung in patients with PAVM no longer oxygenates blood effectively and the direct connections between the arteries and veins prevents the filter function normally present in the lungs. For this reason, patients may be short of breath or cyanotic (blue) because of passage of blood through the lung without oxygenation or they experience strokes or abscesses within the brain because of the absence of the filter function of the lung (which allows passage of small blood clots or bacteria through the PAVM to the brain).

As mentioned earlier, patients may be symptomatic as early as in the newborn period but more often than not, symptoms do not appear until the second or third decade. The risk of brain abscess and stroke is always present hence the importance of screening patients early in life when there is a family history of PAVMs. Other symptoms which can be life-threatening and associated with PAVMs include hemorrhage into the lung. Coughing up of blood (hemoptysis) and hemorrhage into the space surrounding the lung (hemothorax) are dangerous complications. There is some association of these hemorrhagic complications of the lung with pregnancy hence the importance of screening women with HHT before the child-bearing age.

Up until 1978, surgery was required to remove the most affected portion of the lung in order to prevent these complications. Since 1978, embolization techniques performed by radiologists using balloons or stainless steel coils have replaced surgery as the primary method for treatment. Once a PAVM is occluded by these interventional radiology techniques, it will not

recur. Other small PAVMs grow with time and so once a patient has been treated for PAVMs, they must be closely followed by their physician to detect growth of unoccluded PAVMs. Most patients will require additional embolization procedures between six and ten years after their first treatment.

Oral antibiotics before dental cleaning or dental work are necessary for the remainder of a patient's life after the diagnosis of PAVMs has been established. There are always small PAVMs present which may allow bacteria to pass through them after dental cleaning hence the importance of prophylactic antibiotics before dental work.

Much of the serious morbidity and mortality associated with HHT is due to undetected PAVMs. Patients with PAVMs may be entirely asymptomatic if they only have one or two hence the importance of proper screening for this manifestation of HHT.

BRAIN:

Brain arteriovenous malformations and aneurysms are known to occur in patients with HHT. It is difficult to estimate with any certainty how often brain malformations or aneurysms occur. What is known is that once one member of a family has a brain malformation or an aneurysm, probably other members in the family will also be affected. Aneurysms and arteriovenous malformations of the brain may cause cerebral hemorrhage (a form of stroke) and may even be lethal. As mentioned in the previous section, the brain is affected secondarily with stroke and brain abscess in patients with PAVM. In one of the largest subgroup of patients with HHT and PAVM studied by modern brain imaging techniques, abscess and stroke were more common than aneurysm and arteriovenous malformation. What is not known presently is the incidence of brain aneurysm and arteriovenous malformation in HHT patients without PAVMs.

Migraine headaches occur in up to 70% of patients with HHT and PAVM. Migraine headache is often an important clue suggesting that a patient with HHT may also have PAVMs. Embolization of the PAVM may relieve the frequency of migraine headache. Embolization combined with medicines is usually very effective in relieving headache symptoms.

Treatment methods for primary brain aneurysms and malformations have evolved rapidly over the past ten years. Both surgical and interventional radiology approaches are possible for treating brain aneurysms and arteriovenous malformations. Brain arteriovenous malformations of small size can also be treated by radiation. In most instances, when these abnormalities are detected, treatment should be strongly considered.

It appears that in patients with PAVMs, stroke can be prevented by therapeutic occlusion of PAVMs using radiologic techniques. While stroke can be prevented if PAVMs are detected and treated, patients with PAVMs are always at risk for brain abscess and must therefore take prophylactic antibiotics before dental work.

GASTROINTESTINAL TRACT:

Gastrointestinal bleeding occurs in approximately 20% of patients with HHT. Bleeding from the gastrointestinal tract usually does not begin until the fourth or fifth decade. In many instances, oral iron therapy will maintain the blood hematocrit and hemoglobin at near normal values. Some patients, though, require numerous blood transfusions and deaths may occur from bleeding complications associated with HHT.

Treatment for bleeding from the gastrointestinal tract has included laser therapy and surgical resection of affected portions of the bowel or stomach. More recently, hormonal therapy with estrogens and progestones and anabolic steroids has been advanced as possible treatment for intractable bleeding. Certainly over the next decade, significant research needs to be directed to determine the most effective approach for managing bleeding from the gastrointestinal tract for patients with HHT.

It is important not to attribute all bleeding from the gastrointestinal tract to HHT since patients in the fifth and sixth decades with gastrointestinal bleeding may also be bleeding from benign or malignant ulcers or tumors of the intestinal tract. For this reason, gastrointestinal bleeding requires an extensive workup once it is detected but there seems little reason to screen patients early in life for this potential complication of HHT.

SKIN:

Telangiectasias (bright red spots) occur on the cheeks, the lips, the tongue, and occasionally, in the eyelid. They may bleed or be cosmetically undesirable. Modern dermatology using laser techniques can successfully obliterate these telangiectasias.

HOW DO WE ESTABLISH THE DIAGNOSIS?

In order to make a diagnosis of HHT, a patient must have two of the three following criteria:

1. Nosebleeds at least four times per month
2. Telangiectasis of the skin
3. A mother or father with a diagnosis of HHT

While this definition seems straightforward, establishing a diagnosis practically may be difficult in some individuals. For instance, most telangiectasias do not appear until after age 21. At least 10% of patients with HHT will not have nosebleeds but may have the other organ involvement which predisposes them to serious complications. Finally, many patients go undiagnosed because this is a relatively uncommon disorder and many healthcare professionals are unfamiliar with it.

Current textbooks estimate the incidence of HHT among the general population to be 1 - 2/100,000. Most investigators in this field feel this is an underestimate; a more likely figure will probably be 10- to 20/100,000 (25-50,000 affected individuals in the United States). HHT is common in all people of western European origin from Italy to Finland. HHT is uncommon in Afro-Americans and Asians.

SCREENING

The most important step for a family with possible HHT is to obtain a history and physical from a healthcare professional with interest in this disorder or one who is willing to become informed. Once a thorough examination has been performed, then a series of minimally invasive diagnostic tests should be obtained. Most pulmonary arteriovenous malformations (PAVMs) can be excluded by a chest radiograph and arterial blood gases. Brain aneurysms and arteriovenous malformations can be screened for by magnetic resonance imaging.

When Should Families with HHT Obtain Screening?

The answer to this question is not settled definitively, but we can make some general recommendations. If there is a family history of brain hemorrhage, stroke, abscess, or pulmonary arteriovenous malformation, we recommend screening children before adolescence. If the family history suggests none of these more serious complications in family members, then screening of potentially affected individuals should be probably be performed in early adolescence.

The good news is that most of the potentially serious arterial problems can be treated if discovered early enough. Unlike so many genetic disorders where the prognosis is less optimistic, HHT can be treated and affected individuals can lead a relatively normal life.

Robert I. White, Jr., M.D.
Yale University School of Medicine
Chair, Medical Advisory Committee
HHT Foundation International, Inc.
TEL: 203-785-7026 or 203-785-6938

Physicians' Guide to Rare Diseases

Jess Thoene, M.D.

Dowden Press Montvale, N.J. 1992

EDITOR'S PREFACE

The physician caring for a person with a rare disease (one affecting fewer than 200,000 Americans) often is hard pressed to find accurate and timely information about the condition. In a busy practice, an encounter with such a patient can be burdensome. Not in the common stream of daily events, the person's symptoms may be perplexing and the diagnostic tests required may not be readily available. A survey by the National Commission on Orphan Diseases of the rare disease experiences of 247 physicians demonstrated that between 20 percent and 40 percent of physicians could neither find information on the availability or location of appropriate treatment or on the existence of support groups, nor access printed information for patients regarding rare diseases.

The National Commission on Orphan Diseases studied the problems of persons with these rare conditions for two years. Their findings demonstrated that about one-third of these patients do not receive correct diagnoses for over five years. Fifteen percent of these persons went without a diagnosis for over six years. Furthermore, persons with rare diseases desperately want and need information on research projects for patient participation, knowledge of new treatments and research advances, easy-to-understand written information about their rare conditions, and details of the location of treatment centers. None of these is readily available, although the National Organization for Rare Disorders has attempted to meet this need with

the introduction of the Rare Disease Database on CompuServe, providing comprehensible information in lay terms on over 800 rare diseases. Additionally, through its networking function, NORD assists patients with rare diseases in finding other persons with the same conditions, and maintains a registry of treatment centers.

To address the problem of providing more and better information to physicians, NORD and Dowden Publishing Company have collaborated to produce this first edition of *Physicians' Guide to Rare Diseases*. This work is an adaptation of the rare disease database entries for close to 700 rare diseases, and has been revised to address the concerns of physicians in primary care specialties. The intent of the volume is not to provide specialists in rare diseases with comprehensive data about these conditions, but rather to assist someone who encounters rare diseases infrequently by providing ready access to signs and symptoms for help in differential diagnosis, to availability of therapy, and to the location of support groups for these patients.

Each major section of the Guide opens with an overview article by a specialist on the Editorial Board. This introduction is intended as a helpful guide to the diseases covered in that section. Because of its synoptic nature, this book is necessarily inadequate with regard to the details of pathophysiology, diagnosis, and treatment. However, by identifying the rare condition and its major presenting symptomatology, it should shorten the time needed to achieve a correct diagnosis, as well as provide ready access for further information and the location of support groups. This last feature is unique to this book, and we hope it will be most helpful to the practicing physician.

Also featured in this first edition of the Guide is a full-color atlas of visual diagnostic signs; a directory of "orphan" drugs organized by use and providing the name of a key contact person at each research center; and a detailed index of symptoms and key words.

The reader's comments will be most welcome, so that we can make the next edition of *The Physicians' Guide to Rare Diseases* even more valuable. Please address these to me care of the publisher, Dowden Publishing Company, 110 Summit Avenue, Montvale, New Jersey 07645.

I am grateful to the Editorial Board, who undertook to review each article for medical accuracy, and for the outstanding support of Doris

Smith, managing editor, and Carroll Dowden, president of Dowden Publishing Company, who pushed the project along most rapidly. Finally, Abbey Meyers, executive director of NORD, has been the driving force on behalf of rare disease patients in this country for many years, and without her none of this project would have been realized.

—*Jess G. Thoene, M.D.*

Editor

President, National Organization for Rare Disorders

Chair, National Commission on Orphan Diseases

RARE DISEASES: WHAT PATIENTS NEED

Isolation. Hopelessness. Despair. These are the emotions that permeate the lives of rare disease patients in the United States. An estimated 20 million Americans affected by more than 5,000 rare "orphan" diseases find themselves medically disenfranchised, and falling through the cracks of the health care system because their afflictions are not identified as major public health threats warranting targeted research efforts.

How could these problems be documented so that the magnitude of this human tragedy would raise the profile of research on new treatments for rare conditions? As one patient put it, "Orphan diseases are not important, unless you happen to have one yourself."

In the 1985 amendments to the Orphan Drug Act, Congress mandated the National Commission on Orphan Diseases to study all problems related to rare diseases and make recommendations as to how they may be solved. After several years of intensive study, including surveys of the patient and medical communities, the Commission submitted its report to Congress in February, 1989. Following are some of its findings.

Patients and Families

- 31 percent of patients took between 1 and 5 years to receive a

proper diagnosis, and 15 percent went undiagnosed 6 or more years.

- 45 percent of patients said their individual illnesses caused extreme financial hardship on themselves and their families; and 42 percent reported that their diseases prevent them from working or attending school.

Research Findings

- During 1987 the United States government spent \$1.3 billion on rare disease research; the pharmaceutical industry spent \$51.6 million; and foundations spent \$41.6 million. Of the \$1.3 billion spent by the federal government on rare disease research, over half was spent on approximately 200 rare forms of cancer. This left only \$640 million for the remaining 4,800 orphan diseases.

- Biomedical researchers working on both rare and common diseases feel that it is harder to get funding for rare disease research than for research on a prevalent disease, and that the lack of funds is the single greatest barrier to discovery of treatments for rare illnesses. The Commission found that many of the barriers to progress on research and treatments for rare diseases are caused by both lack of funding and a lack of coordination of existing resources.

- 47 percent of researchers reported that it is difficult to find a sufficient number of patients to participate in a research project on a rare disease. In contrast, 76 percent of rare disease patients reported that it is difficult to obtain information about research projects in which they might want to participate.

In a survey of practicing physicians conducted by the Commission in conjunction with the American Medical Association, the Commission found the following:

- 42 percent of doctors say they need, but are unable to find, printed information to give to their rare disease patients concerning their illnesses.

- 39 percent of these physicians had used an investigational drug or device for at least one of their patients; of these, 92 percent said they would do so again. Of those physicians who had never used an experimental treatment, 72 percent said they would not consider using them.

- The sources of information most frequently used by physicians for diagnosing and treating rare disease patients are pharmaceutical companies (46 percent), the Centers for Disease Control (41 percent), and the National Institutes of Health (39 percent).
- A survey of 106 foundations that fund biomedical research indicated that only 12 foundations funded rare disease research grants, representing only 1.3 percent of their medical research budget.
- A survey of rare disease voluntary health agencies indicated that 48 percent of such agencies fund biomedical research grants on orphan diseases. Half of the agencies estimated that the cost of medical care for patients with the disease they represent ranges from \$9,500 to \$115,000 per year (1988 figures).

Obviously, the Commission's report defined many problems, aside from orphan drug development, that affect patients, families, biomedical researchers, and practicing physicians. The tools that clinicians have to identify and treat orphan diseases are few, and the frustrations of patients are many. Today, many issues remain unresolved.

A most important issue is the increasingly acute problem of inadequate health insurance coverage. When a child is diagnosed with a hereditary disease, his siblings (and the affected child) are at risk of losing their health insurance. Expensive treatments can consume a family's health insurance and reach a lifetime ceiling, leaving the patient uninsurable for the rest of his life. When a breadwinner changes jobs, the new employer's health insurance may not cover the preexisting health condition of a spouse or child. If it does cover it, the premiums may be greater than the employee's wages!

Even federal health care programs such as Medicare and Medicaid can present obstacles to appropriate patient care. Hospitals are now reimbursed according to DRGs (Diagnosis Related Groups); but there are no DRGs for the vast majority of orphan diseases. And Social Security Disability or SSI benefits can be denied if a patient's disease is not included in the Social Security Administration's Listing of Impairments. Few rare diseases are listed.

The National Organization for Rare Disorders (NORD) evolved out of a coalition of national voluntary health agencies and support groups

who worked together for passage of the Orphan Drug Act of 1983. In the battle to pass the legislation during the late 1970s and early 1980s, publicity about the orphan drug dilemma resulted in significant influxes of mail from patients and families, asking for information about their disorders and referrals to agencies and clinics where they could be treated.

Their letters and phone calls had common threads which persist today: years of misdiagnosis; absent or ineffective treatment; isolation due to the uniqueness of their symptoms; despair because little or no research was being pursued. Researchers were hesitant to investigate these rare ailments because they felt it would be too difficult to win a grant from the National Institutes of Health (NIH) for an unknown disease. Moreover, they didn't know whether and where they could find sufficient numbers of patients to conduct a clinical trial, and if they were lucky enough to discover a treatment for one of these diseases, they could not find a pharmaceutical company willing to commercialize it. Indeed, in several cases, academic investigators had to manufacture their drugs by hand in their university laboratories for many years, wondering what would happen to their patients if anything were to happen to them.

Today the picture is not so bleak. By the end of 1990, the FDA had designated over 400 orphan drugs and approved 49 orphan products for treatment of 58 orphan diseases, representing significant advancement in the amelioration of many painful and tragic conditions. The Orphan Drug Act has effectively encouraged development of new treatments for rare diseases. Scientists are encouraged by the FDA's orphan drug grant program. Practicing physicians have a larger armamentarium to assist in the diagnosis and treatment of orphan diseases, as well as easier access to crucial intervention.

The future holds the promise of astonishing breakthroughs that will benefit both rare and prevalent disease patients because of America's efforts to develop orphan drugs. Enzyme replacement therapies, drugs to treat AIDS, and human gene therapy are realities today because the government, industry, academia, and patient groups worked together to insure the success of the Orphan Drug Act. But diagnosis still remains a primary problem, and it can only be solved by clinicians who

recognize symptoms early and know where resources are available to affect the course of the disease. To orphan disease patients, however, the major difference between this decade and the past can be summed up in one word: hope.

—Abbey S. Meyers
Executive Director
National Organization for Rare Disorders

**Testimony Before the
Small Business Subcommittee on Regulation,
Business Opportunities and Technology**

June 28, 1993

Martin Schneider

Publisher, *Health Pages*

Good morning. Thank you for the opportunity to testify before this committee. My name is Martin Schneider and I am the publisher of *Health Pages*, a magazine that provides detailed provider specific information to help consumers make informed health care decisions. Let me give you some brief examples of the type of information I publish. A recent issue in Wisconsin informed readers that one local doctor charges \$2,500 for maternity services while another charges only \$1,250 and that one area hospital has a cesarean section rate of 21% (one in five women) while another has a rate of only 10% (one in ten women). The purpose of actively disseminating this information is to help change today's patients into tomorrow's health care consumers and to introduce accountability into the health care system. The dissemination of this information will provide market incentives to health care providers to improve the quality of their care.

I would like to speak to you today about, first, why access to comparative information on health care providers is critical to an efficient health care system, and second, what the federal government can do to foster the collection and dissemination of that information.

Creating An Accountable System By Empowering the Health Care Consumer

Seven years ago I established a health care management firm which set-up and operated medical facilities including x-ray centers, laboratories and home care companies. My previous business training did not prepare me for the lack of competition I found in my corner of the health care delivery system. There was no real competition and no requirement of accountability for the services my facilities provided. As long as our marketing and turn-around time was adequate, patients and referring physicians never asked us the most important questions like what was the quality of the service we were selling, and even more fundamentally, at what price were we selling it?

No one asked about the quality or age of the equipment, the training of the technicians, or the backgrounds and experience of the physicians that worked in the facilities. Because there was no flow of basic information to our consumers, there was no incentive for us to offer the highest quality services at the lowest price. There were no market forces which led us to be as efficient as we could or to maximize the quality of our product. This experience demonstrated to me that the free flow of information was crucial to any competitive system and in the case of health care would dramatically improve both the quality and efficiency of the U. S. health care delivery system.

The collection and dissemination of health care information is an industry in its infancy and is regrettably one that has been controlled and stymied by the current providers themselves. Knowledge is power and the providers well understand this fact. When people pay for health care, or any service, they have a right to know what they are getting. The seller of the service should no longer be dictating the terms of the transaction. For a democratic health care system to be in place, people need information, and information will give them an ability to freely chose and evaluate their health care choices in a rational and efficient manner.

Health Care Patient to Health Care Consumer

Under many, if not all, of the reform scenarios under debate, consumers will be more involved in their own health care decisions than they have been in the past. A central tenet of most health care proposals is the idea of consumer choice. Yet, we are only beginning to understand how consumers actually make choices in health care, and what specific information will make it easier for consumers to make informed choices.

Historically, individuals have been passive participants in the health care delivery system. The evolution of individuals from passive patients to actively engaged consumers will

involve a key initial stage. This stage is getting people access to information which highlights the price and quality differences between physicians, between hospitals, and between health care plans. While individuals have traditionally understood that there were differences in such characteristics as bedside manner, few understood that there might be significant differences in clinical approach, medical outcome and cost of service. Pricing, the factor patients have been most reluctant to question, has served as a misleading differentiating factor. Unfortunately, many patients have assumed that higher priced providers give higher quality care. That assumption is not necessarily accurate.

The pioneering small area analysis work of Dr. John Wennberg, the research on appropriateness of care by Robert Brook, numerous articles in the medical research journals, and most recently the work of State data commissions, like Pennsylvania and New York, all demand the reversal of the assumption that all providers are alike. During the first stage of evolution from passive patient to active consumer, individuals need to understand that all providers' services and prices are not alike.

Once consumers accept that there are differences in medical practice and approach, they will want to know more about the physicians and hospitals they use. Increasingly, as consumers are asked to choose between managed care plans they will want to know about each plan's performance, which doctors are in the plan, how these doctors were selected, how the plan assures doctor's performance and how well the plan meets its enrollees' needs. As this type of information becomes more widely available and easily accessible through publications like *Health Pages*, we will begin to enter the next stage of the evolution: that of the actively engaged health care consumer. Indeed, part of the mission of *Health Pages* is to help educate and empower consumers so that they will create additional demands for information. At some point in the not too distant future, consumers will look back at the early 1990's with amusement, reflecting on the time

when detailed, accessible information about health care providers and plans was not readily available.

Challenges in Dissemination Health Care Information

While this evolution from patient to consumer is already happening through the explosion of information in the popular press and magazines such as *Health Pages*, it is important not to underestimate the difficulty in effectively communicating this type of information to consumers. First, there is often a deeply-held emotional relationship between physicians and patients (e.g. polls often show general dissatisfaction with physicians, but positive responses regarding an individual's own physician). It is difficult to empower patients without threatening the basic trust between physicians and patients which is a key part of a healing process. Second, there is little consensus on what some of the information means, that is, what is the "right" price or the "right" treatment. Third, there will always be individuals who do not want any responsibility for the decision making inherent in health care consumerism. Their safety and wishes must also be respected. So, there will always be a need for public oversight of the health care system and a need for other types of intermediaries who might act on these peoples' behalf (including employers, purchasing alliances, consumer groups, publications, etc.). Finally, we need to better understand what types of information the consumer finds most valuable and how to effectively communicate that information.

There is another practical set of barriers which make it difficult to collect and distribute information to health care consumers. In most cases, comparative information about providers or plans is simply not available, or not publicly available. Today there are only 37 states that mandate the collection of health data and out of these only three states Wisconsin, Arizona, and North Carolina allow for the release of physician-specific data. In other instances, the information has been available but compiled by a government

agency in a format that is not easily accessible to consumers. Other barriers to publishing comparative data include the need to audit the data, the need to be accurate with the information but not publish so many caveats that the data loses its value and the sometimes aggressive resistance by organized physicians and hospital groups.

Health Pages: Background and Goals

Health Pages is leading the way in communicating health care information to the public by providing straightforward objective data such as which doctors are board certified, and what physicians charge for their services. The first issue of *Health Pages* was in the Sarasota, Florida area and included a comparative Medicare price listing of all local doctors. The magazine was well received by local businesses and consumer groups. As market feedback was received, the magazine now includes disease specific educational articles, providing general preventive, diagnostic and treatment information. These articles are woven together with information on local choices of providers who treat each particular health issue.

Let me give you an example. In our Spring 1993 Wisconsin issue the article on breast cancer included general information on the frequency of the disease, who is at risk and guidelines for preventative measures like mammograms. This information is not unique. *Health Pages* though, takes the next step by providing comparative comprehensive information on 32 local mammography facilities. The detailed information on each facility includes whether a breast exam is given and by who (a doctor or nurse), whether the facility has weekend hours and also basic quality information like whether the office has been accredited by the American College of Radiology (ACR). Pricing information is also included and reveals a dramatic range of charges from a low of \$49 for a mammogram to a high of \$189--a 286% difference. It is interesting to note that the

facility that charges \$49 for a mammogram has been accredited and the facility that charges \$189 has not.

Let me share with you some other differentiating information that consumers have learned about their providers from the Wisconsin issue:

Which **doctor** charges \$1,250 for maternity services and which one charges \$2,500--a 100% difference?
 Which **doctor** charges \$2,342 for a prostatectomy and which one charges \$4,410--a 88% difference?
 Which **doctor** has a 6% Cesarean section rate and which one has a 52% rate--a 767% difference?

Which **hospital** has a 10% Cesarean section rate and which one has a 21% rate--a 110% difference?
 Which **hospital** charges \$1,589 for a maternity visit and which one charges \$2,457--a 55% difference?
 Which **hospital** charges \$36 for a prostate test and which one charges \$135--a 275% difference?
 Which **hospital** charges \$49 for a mammogram and which one charges \$184--a 276% difference?

Health Pages was received with great interest by both the press and the public. *Health Pages* is expanding into the St. Louis metropolitan area with an issue available this September. This issue will focus on managed care plans. We expect to receive "report cards" from the local plans which will be published, for the first time ever, in a comparative format for consumers in St. Louis. The St. Louis Business Health Coalition helped bring the magazine to the area by committing to purchase a minimum of 20,000 copies to distribute to their members' employees and retirees. We are currently talking to many other business coalitions throughout the country and expect to be printing in half a dozen other states within the next year.

The Federal Role in Consumer Health Information

How can the federal government assist in the gathering and distribution of consumer information? There are several specific measures you can take:

- 1) Make a public and highly visible commitment to the monitoring of health care by insuring that comparative information is collected and distributed to the public.
- 2) Mandate that the information collected include the prices and outcomes of treatment options, consumer satisfaction levels and the comparative performance of providers.
- 3) Establish a uniform data reporting system which will insure that information collected is truly comparative.
- 4) Insure that data collection and availability be continuous through ongoing funding commitments.
- 5) Fund AHCPR and other groups to do research to better understand consumer decision making.

Let me conclude my comments with a concrete example of how information, properly gathered and widely distributed can immediately, improve the quality of care, decrease health care costs and turn patients into health care consumers.

A Cesarean section is the most common operation in the U.S., and currently occurs in 24% or nearly one out of every four deliveries. In recent years the American College of Obstetricians and Gynecologists stated that the C-section rate is too high but has opposed setting a national target rate. This past April, the Centers for Disease Control and Prevention reported that the medically appropriate rate should be 15%. If this rate was achieved nationally there would be 349,000 fewer Cesareans a year, and an annual savings of over \$1 billion dollars. Reducing the number of C-sections sounds like a worthwhile goal--improve the quality of care and save billions of dollars at the same time. Let me suggest a way that collecting and disseminating consumer information can accomplish this.

Various states have mandated that hospital specific C-section rates be made available to the public. This information is not terribly useful for consumers because people generally do not choose a hospital for maternity services rather they choose a doctor. A more appropriate set of data would be C-section rates for individual doctors. This information, properly explained and adequately distributed would unleash the power of consumers and set in motion proper incentives for obstetricians. In the Wisconsin issue, we published, for the first time ever in this country, individual physician C-section rates. I have been told by many doctors and several hospital medical directors that if obstetricians know that C-section rates will be published on a regular basis, many unnecessary C-sections will no longer be performed. C-section rates will begin to fall very quickly once you bring the consumer into the picture.

Maternity services are an extremely common and highly visible medical service. This committee may want to consider sponsoring legislation that would mandate the public availability of physician-specific C-section rates just as Representative Wyden successfully sponsored legislation which required that infertility clinics release their success rates. The results of this C-section legislation would demonstrate differences between providers, engage consumers, establish physician accountability and lower health care costs.

Health Care Information Helps, Not Hurts

Critics claim that Americans are not smart enough to make their own decisions about health care or health care plans. These critics underestimate the American public and the power of information. You no more have to be a doctor to make all health care choices than you have to be a mechanic to buy a car.

There was a test case on the release on information in New York and the outcome is instructional for us all. The New York State Health Department had finished a study which produced severity adjusted physician-specific coronary artery bypass graft surgery (CABG) rates. The State refused to release the information to the public arguing that the data would be misused and misunderstood. Newsday, a Long Island based newspaper, sued the state under the Freedom of Information Act. In October, 1991 State Supreme Court Justice H. Hughes rejected the State's argument that "the state must protect its citizens from their intellectual shortcomings by keeping from them information beyond their ability to comprehend. Following the department's position to its logical end, it appears that if members of the public were more intelligent it would be in the public's interest to disclose this information." Protecting people from information is not the democratic American way. Arming consumers with information and helping them to protect themselves is the American way and is critical to a more efficient health care delivery system.

Thank-you for the opportunity to testify before you this morning and look forward to answering any questions or providing additional information.

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 GREEN BAY/MADISON/MILWAUKEE EDITION

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Dear Reader:

Thank you for picking up this copy of Health Pages. Reading this publication can help you become a better consumer of health care in Wisconsin. As more individuals begin to examine and challenge the American health care system, costs will go down, quality of care will improve, and more people will be served more appropriately.



NATIONAL SMALL BUSINESS UNITED

1155 15TH STREET, N.W.
SUITE 710
WASHINGTON, D.C. 20005
202-293-8830
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Many small business owners and their employees are becoming very aware of skyrocketing health care costs. They are frightened and overwhelmed by the impact of these costs on their businesses and their jobs. The average cost of health insurance for a small business employee and his or her family has grown from an annual premium of \$690 in 1980 to nearly \$4,500 in 1992.

Health Pages is responding to these concerns by teaching consumers how to get the most from their health care. National Small Business United (NSBU) is proud to be a major sponsor of this publication. NSBU is a national not-for-profit association of small businesses and small business organizations with more than 65,000 members from around the United States. NSBU is especially pleased to be affiliated with the **Independent Business Association of Wisconsin** and the **Council of Small Business Executives** in the **Greater Milwaukee Chamber of Commerce**. Together, we are making every effort to advocate on the federal level in the best interests of small businesses and their employees concerning issues like health care reform.

As such NSBU is participating in discussions on the national level, focusing on the need for cost containment and greater personal responsibility in our health care system. We seek your ideas, your input, and your support of our efforts. You can join us by contacting any one of our organizations. You are needed to educate and inform members of Congress how changes will affect you, your business, and/or your employees. So please make time to call or write us now!

We encourage you to take charge of your health care and act more like a consumer of health care instead of simply a patient of the health care system. You can make wise and valuable decisions regarding your health. All you need is more information about the care you are being delivered. Tell others to purchase this publication, too. It is so important that more people learn about our health care system. NSBU wishes you a long and healthy life!


John Paul Galles, Executive Vice President

HEALTH PAGES

H IN THIS ISSUE

2 LETTER FROM THE PUBLISHER**3 HOW TO USE THE HEALTH PAGES**

Much of the information you'll find in these pages about your local doctors and hospitals has never been published before. Here's how to make sense of it.

6 MONEY TALK

How high are Wisconsin's health care costs compared to the rest of the country? Plus tips on how to stretch your health care dollar and get the most out of your insurance.

MEN'S HEALTH**28 PROSTATE ALERT**

Prostate cancer is every man's nightmare. But it doesn't have to be. The key is early detection. Here's how to tell if you've got a problem. Plus a guide to local urologists.

WOMEN'S HEALTH**35 BREAST CANCER: WHAT YOU NEED TO KNOW**

Information on prevention, detection, diagnosis and treatment that could save your life. Plus a comparative guide to mammography facilities, oncologists and surgeons in your area.

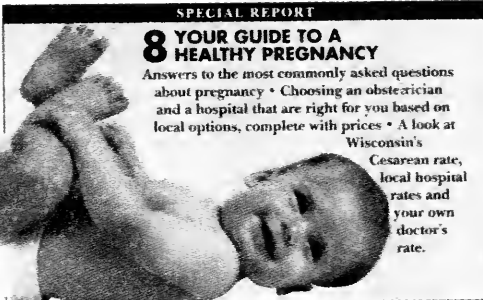


Additional copies of the Health Pages can be ordered by sending a check or money order for \$3.95 (plus \$2.00 shipping and handling) to Health Pages, c/o West Pub. Co., 120 West New York St., NY 10041. For information about bulk purchase discounts contact 212-929-6131.

SPECIAL REPORT**8 YOUR GUIDE TO A HEALTHY PREGNANCY**

Answers to the most commonly asked questions about pregnancy • Choosing an obstetrician and a hospital that are right for you based on local options, complete with prices • A look at Wisconsin's

Cesarean rate, local hospital rates and your own doctor's rate.

**SENIORS' HEALTH****44 MEDICARE & MEDIGAP MADE EASY**

New government regulations make it easier than ever for Medicare patients to buy supplemental health insurance. This comparative guide to statewide Medigap insurance options helps you be a smart insurance shopper.

WELLNESS ISSUES**54 WEIGHTY MATTERS**

How can you differentiate between a snake oil treatment and a weight loss program that really works? Here's a reality check along with a guide to local weight management programs.

56 GUIDELINES FOR DOCTORS & PATIENTS

If you haven't got time for the pain, check out this section for the latest government recommendations on pain control after surgery.

58 PHYSICIANS' FILE

Useful background information on doctors and the office services they provide.

CHILDREN'S HEALTH**51 TONSILS: IN OR OUT?**

Tonsils aren't necessary. Right? Wrong. Today's thinking on whether your child's tonsils should come out could surprise you. Plus a guide to ENT Otolaryngologists in your area.

HEALTH CARE OPTIONS**48 HOUSE CALLS: ALL ABOUT HOME HEALTH SERVICES**

If someone says homemaker do you think housewife? Here's a look at home nursing options, with a list of home nursing agencies close to your home.



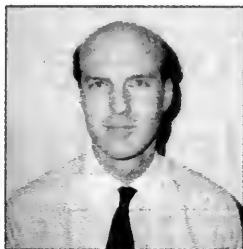
A Letter from the Publisher

WELCOME TO THE WISCONSIN HEALTH PAGES! Because we believe that all health care consumers are entitled to accurate information about their health care, the HEALTH PAGES educates readers about illness, provides price and service information on local doctors, hospitals and other medical professionals and offers helpful service-oriented tips. We hope the information will help you to be a more informed and responsible consumer of medical services.

The HEALTH PAGES does not recommend that you use our information as your sole source for choosing a doctor, picking a hospital or deciding on a home nursing service. Our listings are simply meant to help you take a more active role in these decisions. We hope they lead you to ask more questions of your doctors and to think of yourself not only as a patient but also as a health care customer.

Clearly we are not suggesting that patients act as their own doctors. That would be ridiculous. Medical professionals know infinitely more about health care than consumers.

However, that does not mean that pricing, services and quality should remain a mystery to the public. Traditionally, as consumers, we have not required of the medical profession what we have come to expect from other sellers of products or ser-



vices we purchase. The first step in demystifying health care is being informed. After all, how can you be a responsible consumer if you are not equipped with the facts? The HEALTH PAGES provides you with the basic facts about health care and your local health care providers.

Our goal is to make the health care industry more open so that consumers can learn about the services they receive, the relative prices they are charged, the alternatives available to them and, someday, the quality of the services they are receiving.

This is a tall order for the HEALTH PAGES. We want to bring democracy to our nation's largest and perhaps most important industry. We want to bring the public the most pertinent information available on its local medical providers. People around the country are working to make these goals a reality, and we are excited to be part of that effort.

We welcome you as a co-participant and hope you enjoy this issue.

Martin I. Schneider
Publisher/Editor

HEALTH PAGES

Publisher/Editor
MARTIN I. SCHNEIDER

Executive Editor
RACHEL HAGER

Art Director
ALEX SILBERMAN

Researchers
VICTORIA CHIN
CHRISTINE MARCUCCI
HELAINE NEIMAN

Senior Advisor
CAROL CRONIN

36 West 15th Street
12th Floor
New York, N.Y. 10011
212-929-6131

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The listings in this magazine have been collected for the convenience of the reader. Listings are not presented as inclusive. The listings of health care providers do not constitute a recommendation or endorsement of any individual, institution or group. The publisher disclaims any liability arising directly or indirectly from the use of Health Pages and advises users of the publication to exercise their own informed judgment in the selection of medical care.

While the editor has attempted to publish the information as accurately as possible, Health Pages regrets any omissions or errors and cannot be held liable. The reader is strongly advised to contact the individual providers to verify the information.

How to Use The Health Pages

Most magazines don't come with instructions on how to read them. You sit down, you open them up and you read. But the HEALTH PAGES is a little bit different. Although it's chock full of interesting articles and service-oriented tips, it also contains lots of data and information that you

as a consumer might not be used to seeing. What follows is a brief explanation of the various sections of the magazine to help you interpret and better understand the information they contain.

Use it as your guide to get the most out of the HEALTH PAGES and your health care.

UNDERSTANDING THE GUIDE TO PHYSICIANS

The "Guide to Physicians" sections throughout the magazine provide you with basic factual information about doctors' fees, services and educational backgrounds.

Patients can use the information to compare doctors' prices before services are rendered and to search for a new physician based upon his or her background and the services offered.

Physicians and other health care providers can use the information to learn how their prices compare with their colleagues', and as a source book for specialist referrals for their patients. Employers can use the data to help their employees reduce their health care expenses.

The information in the "Guide to Physicians" is not intended to endorse or recommend any individual physician. There is little objective information

available enabling us to judge the quality of care provided.

We urge you to carefully review the listings in the HEALTH PAGES and to consult with your family, friends and others who might have experience with a particular physician for additional background information. While the HEALTH PAGES is a valuable guide in your search to learn more about health care providers, ultimately, only you can determine if a physician meets your needs.

UNDERSTANDING YOUR DOCTORS' FEES

• *Why do prices vary so much?*

There is no easy answer to this question. Physicians often do not know what their peers charge. Some are unaware that their fees are at the high or low end of the scale.

Lower fees might indicate that a doctor is comfortable charging a lower than average price and limiting his salary. A higher fee schedule may indicate that a doctor has new office equipment, a high rent, or additional medical staff to help with insurance billing procedures. Or it may be that no one has ever questioned the doctor's higher price policy.

Since patients have been kept uninformed about price differences among physicians, and rarely know, or ask, the charge for a particular procedure until after it has been performed, it is difficult for patients to do any price comparison shopping when looking for a doctor. Consequently, there is little incentive for physicians to compete for business based on their fee schedules.

The HEALTH PAGES' physician fee listings make the price variations among physicians public. If you have a question about your doctor's fees, ask.

HEALTH PAGES

• *What do the fee listings tell me about the quality of the individual doctor?*

Unfortunately, nothing. The price schedules give no information about quality of care and are not meant as an endorsement or recommendation of any individual physician.

HOW ACCURATE ARE THE LISTINGS?

Because there is an inevitable delay between the time information was collected (October and November 1992) and the time of publication, we suggest you call the offices of the physicians you are considering to verify the information printed here. We also encourage you to speak with the physicians about any information in the listings you do not understand.

The data on office services, doctors' backgrounds and fees were generally compiled from the returned surveys. In some instances, the HEALTH PAGES contacted the provider's office directly by phone.

It should be noted that the prices listed are for 1992. Most providers will have increased their fees for 1993. You can assume, though, that a doctor's prices will remain the same, relative to what other physicians are charging.

HOW WERE THE DOCTORS INCLUDED IN THE LISTINGS CHOSEN?

OB/GYN: In an attempt to present information on the obstetricians with the busiest practices in the three metropolitan areas, the HEALTH PAGES requested from the state's Department of Health a listing of all physicians who had delivered at least 50 babies a year in both 1990 and 1991. These physicians were then mailed a survey by the HEALTH PAGES that queried them about their backgrounds and office services. They were told their responses would be published free of charge.

Urology/ENT/General Surgery/Oncology: The HEALTH PAGES sent mailings to physicians in these specialties whose names we received from the state's Department of Professional Regulation. If your doctor is not listed in our pages, it means that either he or she chose not to return the written survey or respond to our phone surveys, or, very likely, was never contacted—he or she may have simply slipped through our system of finding providers in a particular specialty.

WHAT IS BOARD CERTIFICATION?

A board certified physician is one who, after completing a residency program, passes an examination administered by a group of specialists or board. It is important to remember, though, that board certifica-

tion does not guarantee high quality and that some qualified physicians may not be board certified. New physicians, for example, may not have spent enough years in private practice to be able to have taken their boards.

Up until recently, certification was good for life. But now, some specialties, including obstetrics/gynecology, have started placing a ten year limit on certification standing. Consequently, some doctors have applied for and received recertification. This is why in going through the listings, you will notice that some doctors have two separate certification dates.

A NOTE OF THANKS

We thank the physicians who responded to our surveys and would like to point out to our readers that these doctors are eager to have you, the consumer, learn about their backgrounds and practices. Their openness demonstrates a fundamental respect for patients and their right to be informed health care consumers.

We hope that future editions of the HEALTH PAGES will include information on an even greater number of doctors as physicians come to understand the value of this information to their patients.

DOCTORS' FEES GO PUBLIC

In 1992, the American Medical Association (AMA) adopted a policy that physicians be required to make information on the prices they charge for frequently provided services readily available to consumers. As one way of implementing this policy, the AMA has suggested that physicians make their prices available for publication in directories and that prices for services be posted in doctors' waiting rooms. The goal: To enable patients to compare costs more easily and benefit from increased competition among doctors. The AMA would like to see hospitals, laboratories and other health care providers follow their lead in recommending that price information be made available to the public.

HEALTH PAGES



UNDERSTANDING THE HOSPITAL LISTINGS

Much of the responsibility for choosing a hospital rests with your doctor, but you, too, must play an important role. You should keep in mind that different hospitals have different strengths and weaknesses. The right hospital for one patient may be the wrong one for another.

Your choice of hospital will generally be more limited if your family doctor wants to admit you to a hospital under his or her own care. Most doctors have admitting privileges at only a few hospitals or a single hospital.

There is a good chance, though, that your doctor will refer you to a specialist who will arrange for your admission. Still, the specialist will probably be one who practices at one of your doctor's hospitals, since these are usually the specialists your doctor knows best. Also, your doctor may want to see you in the hospital and work with the specialist.

But your choices need not be limited to your doctor's hospitals. In many cases, it is not necessary for your doctor to remain active in your case while you are under a specialist's care. You may then be referred to a hospital where your doctor does not have attending privileges.

READING THE CHARTS: AVERAGE HOSPITAL PRICES

The fees listed are the average prices charged by various hospitals from January 1 to December 31, 1991 for specific procedures. The prices include: hospital services ordered by the physician (x-rays, labora-

tory tests, medications); hospital room; medical supplies used in treatment; and routine personal care items such as surgical gowns. The fees listed do not include physician fees for services billed directly to the patient by his or her physician.

• Will my bill be exactly the amount listed?

Your bill may be higher or lower than the amount listed in the table. If you enter the hospital less sick than the average patient and you require fewer tests or a shorter hospital stay, then your bill will probably be lower. If, however, your illness is more severe and you require a longer stay and/or more tests, your bill will probably be higher. Your doctor's style of practicing medicine (how many tests he or she typically orders, how much care he or she thinks is routinely appropriate) may also affect the size of your bill.

• Why do prices vary for the same procedure?

Several factors influence a hospital's fee schedule, including the cost of supplies, material and equipment; the wages paid to employees; the percent of occupancy at the hospital; how many services are provided free of charge and overall hospital management efficiency.

• What do the prices say about the quality of the care I will receive?

Nothing. Unfortunately there is still no easy way of evaluating the quality of care a hospital provides. It is important to understand that there are legitimate differences in rates while keeping in mind that higher prices do not necessarily mean better care.

HOW INFORMATION WAS GATHERED

The HEALTH PAGES requested maternity, mammography, weight center and home health care information from 20 hospitals in the Green Bay, Madison and Milwaukee areas. The response was very positive—18 of the hospitals provided us with information. We thank the hospitals for their cooperation.

NOTE: St. Joseph Hospital and Elmbrook Memorial Hospital chose not to provide us with information. We regret this decision and hope that in the future they will see the value of their current and prospective customers learning about their services in the HEALTH PAGES.

Money Talk

In this time of rising health care costs it makes sense to try to save money where you can. You *can* cut down on your medical expenses without cutting corners on quality of care. Here's the latest on the cost of health care in Wisconsin along with helpful money saving tips.

THE GOOD NEWS: How much you can expect to pay for your health insurance benefits depends a great deal on where you live, according to a survey of insurance rates conducted by Milliman & Robertson, a New York City actuarial firm. The survey found a wide disparity in costs for a typical package of group health insurance benefits in the 400 largest U. S. metropolitan areas. On a positive note, *Green Bay's package was the second least expensive.* The monthly cost of group health insurance benefits in Green Bay was only \$266/month, or 27 percent less than the national average of \$365 per person. The cities of Madison and Milwaukee also fared well, with Madison's costs 18 percent below the national average at \$299 (ranking the city 324) and Milwaukee's costs 11 percent below the national average at \$325 (ranking the city 227).

Some factors that account for the difference in costs: The frequency with which various services are used, how expensive those services are and how much it costs to do business (rent, salaries, etc.) in the city in general. Costs tend to be highest in the largest cities.

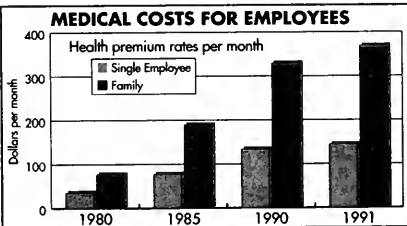
Lab costs vary as well—even locally. If you check the

prices of lab tests in your area, you'll find a surprising difference in fees for the same tests. For example, medical laboratories in Milwaukee charged anywhere from \$36 (St. Luke's Medical Center) to \$135 (St. Joseph's Hospital) for a PSA test in 1992 (see p. 30). Milwaukee County Medical charged \$28 for an AFP test, while Damon Laboratories charged \$113 (see p. 25). So, if saving money is important to you, compare lab fees and discuss them with your doctor.

THE NOT SO GOOD NEWS: For mid-sized employers, the total cost of providing employee health benefits in 1991 averaged \$3,546 per employee, up 15.2 percent from 1990's \$3,079, according to a study by Foster Higgins, a Costa Mesa, CA benefits consulting firm. Health care benefits accounted for 10.9 percent of total payroll expenses. The cost of corporate health care benefits as a percentage of corporate earnings is rising quickly, too—almost doubling between 1989 and 1990 from 26 percent to 48 percent.

Companies are passing along these rising health care costs to their employees. According to a *Business and Health* survey, more than 75 percent of companies have increased employee deductibles and 69 percent have raised their employees' share of health insurance premiums. In fact, in 1992, consumers spent 14.6 percent of their incomes on medical care, up from 13.5 percent in 1991 and only 9 percent in 1980.

Wisconsin has the third healthiest population in the U.S., according to a 1992 study by Northwestern National Life Insurance Co. in Minneapolis. That moves the state up from a ranking of seven two years ago. This is largely due to greater support for public health care, a reduced risk of heart disease and better employment rates. The rankings are based on an evaluation of 17 components that measure disease, lifestyle, access to health care, mortality and occupational safety and disability.



HEAD PAGES

CONSUMER TIP: UNDERSTAND YOUR MEDICAL BILLS AND SAVE MONEY

Perhaps the easiest way to save money on soaring health care costs is to carefully review both your medical bills and the explanation of benefits forms you receive from your insurer.

INSURANCE COMPANY ERRORS

One of the most common errors made by insurance companies is miscalculation of the family deductible. For example, your plan may have a deductible of \$200 per person and \$400 per family. But the claims office may neglect to add up all of your family's bills, so individual family members might still be dishing out money toward their deductibles even if the family has already met the \$400 requirement.

A similar error can occur if the claims office neglects to calculate your annual total out-of-pocket limit, or what the industry refers to as the "family stop-loss limit." Once you have paid this amount—generally between \$1,000 and \$2,000—the insurance company pays 100 percent of all other costs for the remainder of the year. So be sure to keep a careful tally of individual as well as total family payments.

HOW TO SAVE MONEY ON YOUR DOCTORS' FEES

If your health insurance covers 80 percent of doctors' fees, that means your costs are 80 percent covered. Right? Wrong!

Eighty percent coverage means 80 percent of the insurance company's "reasonable and customary" doctors' fees. Your insurance company will only pay 80 percent of the amount it considers reasonable. But what if your doctor is more expensive? What if he or she charges \$4,000 for a procedure your insurance company thinks should cost \$3,500? Your insurer will only pay 80 percent of the \$3,500, or \$2,800. That leaves you with \$1,200 to pay! So find out ahead of time how much your insurance company will pay for a procedure—and if the procedure is covered to begin with—otherwise your bill may surprise you. Also, tell your doctor, that you want to make sure his or her fee is covered by your insurance. Many physicians will agree not to charge more than the reasonable and customary charge.

HOW TO SAVE MONEY AT THE HOSPITAL

- If you can, keep a log. Assuming you're up to it, you—or a family member—should attempt to keep a daily record of the services, medications and other supplies you receive. You can find forms for logging tests and medication in *Take This Book to the Hospital With You* (The People's Medical Society).

- If you need surgery, ask your doctor if it can be performed on an ambulatory, outpatient-basis or on

the day you are admitted to the hospital. If not, ask your doctor if it's possible to schedule your surgery early in the week, so you won't have to spend the weekend in the hospital if you're well enough to go home.

- Try to have the necessary x-rays, lab tests and blood work done outside the hospital, before you're admitted. This can save you at least a day or two of hospital charges.

- When you get your bill, check it carefully to make certain that you are not being charged for a procedure you didn't have or equipment you didn't use. If you get a bill with just summary charges ask the hospital for an itemized breakdown that includes a description of each procedure.

- To make sure the charges are correct, start with the obvious: The room rate and number of days, plus charges for major procedures, operating room, recovery room, etc. Then, compare the remaining itemized charges against your medical records. Although this might take some time, it could very well save you money.

FIVE SMART MONEY-SAVING TIPS

1 Don't repeat medical tests needlessly. If you change doctors or dentists, have your new practitioner obtain copies of your past records and x-rays.

2 Buy generic drugs, both over-the-counter and prescription, and shop around for the best price, if possible. Generics, which have the same active ingredients as their brand-name equivalents, are almost always as safe and effective as name brands—but they are usually a lot cheaper. Ask your doctor to prescribe generics when they're available.

3 Consider buying prescription drugs from mail-order pharmacies. Mail order firms often charge less than your local druggist. One caveat: They can't fill prescriptions as quickly. But they're perfect for patients taking medication for long-term conditions, such as high blood pressure or heart disease, in which timeliness is not such an issue. Some resources that offer discounted mail-order drugs: Pharmail, 800-237-8927; Action Mail Order Drug, 800-452-1976; Medi-Mail, 800-331-1458; and the American Association of Retired Persons (AARP), 800-284-2277. The AARP service is available only to members (you must be 50 or older and pay a \$7 annual fee).

4 Avoid emergency rooms except in true emergencies. Show up at an emergency room at midnight with a problem that can wait until morning and you lose twice: You pay top dollar, and you wait for hours while the real emergencies are taken care of. If your doctor is not available, try one of the 24-hour urgent-care centers that have sprung up in recent years.

5 Get your children vaccinated, and make sure you are protected, too. Although insurance may not cover their costs, immunizations are among the biggest bargains in medicine. Keep records and get boosters when needed. Get flu shots, too, especially if you can't afford to miss work for a week or more.

Your Guide to a Healthy Pregnancy

Your doctor tells you that you're pregnant. If you're like most women, you go from unrestrained euphoria to high anxiety in the span of a few minutes or less. Hundreds of questions and concerns take control of your mind: What should you eat or not eat? Are there

things you can do to help your baby develop properly? What should you expect once the big day arrives?

Learning about pregnancy and good prenatal care (including proper nutrition and exercise) can reduce or eliminate serious risks for both mother and child. Complications during labor can be averted. And risk factors like low birth weight (under five and a half pounds), which is associated with an estimated 300 percent increase in other birth defects, can often be prevented.

Another good reason to learn about pregnancy: Education provides options. It makes choices appear where superstition, dictates and customs previously ruled.

Lastly, learning about pregnancy can help alleviate the fear of the unknown that often accompanies a woman's discovery that she is pregnant. We are all frightened of things we do not understand. Once understood, pregnancy can not only be better managed, it can actually be enjoyed.

A GOOD DIET: BUILDING BLOCK FOR INFANT HEALTH!

Some people believe that the fetus will get all the nutrients it needs from the mother's body. This is both true and untrue at the same time. *The foods a pregnant woman eats are the foods her baby eats.*

The special nutritional needs of the growing baby make it particularly important for the mother's diet to be nutritionally sound. If, for example, you're not eating enough calcium-rich foods, the baby will sap your own stores of the mineral to get the amount he or she needs.

If you're lacking certain nutrients, the baby will, too. Through her diet and the care she takes, a mother-to-be gives her child a poorly or well-nourished body.

DIET DOS AND DON'TS

1. **Eat a wide variety of foods.** A well-balanced diet means eating a variety of good foods like fruits, vegetables and grains, as well as dairy products (milk and cheeses) and proteins (meats, fish, eggs, nuts and beans). It is important to eat foods from each of these groups every day to ensure that the baby gets all the nutrients he or she needs in order to develop properly.

2. **Avoid added sugars and fatty or fried foods, and eat whole grains only.** Foods lose many important nutrients when they are processed.

3. **Eat smaller meals more frequently.** During pregnancy, your stomach and intestines are pushed up and back by your expanding uterus and the growing baby. You may find that you no longer have room for large meals. Smaller meals, eaten more frequently, will leave you feeling far more comfortable since they are more easily digested.

By nibbling throughout the day, you can also help forestall nausea, a common complaint of pregnancy. Morning sickness (nausea in the morning) can sometimes be prevented by eating a light snack in the middle of the night or a little something, like crackers, before getting up in the morning.

WEIGHT GAIN

The weight you gain during pregnancy helps your body nourish your growing baby and produce the milk you'll need for breastfeeding. There's no magic number when it comes to the amount of weight a woman should gain while she's pregnant, but the average healthy woman gains between 25 and 35 pounds. Expect to gain about 10 pounds during the first 20 weeks and about one pound per week for the remainder of your pregnancy.

However, don't take the need to gain weight as a license to binge on junk food. Remember, the important thing is not how much weight you gain, but the kinds of foods you're eating to gain it. Here's how the weight breaks down:



7 POUNDS
Maternal stores
(fat, protein and
other nutrients)

4 POUNDS
Increased fluid
volume

4 POUNDS
Increased blood volume

2 POUNDS
Breast enlargement

2 POUNDS
Uterus

6-8 POUNDS
Baby

Adapted from the American College of Obstetricians and Gynecologists.
Nutrition During Pregnancy ACOG
Patient Education Pamphlet
#AP001 Washington, DC, ©1992.

4. Drink plenty of fluids, especially water and juices.

Doctors recommend pregnant women drink at least eight glasses of water each day. More fluids are needed during pregnancy in order to support the increase in the mother's blood volume and maintain the amniotic fluid surrounding the baby. Increased fluid intake also helps prevent constipation. Avoid caffeinated drinks like coffees, teas and colas. And stay away from all alcoholic beverages.

DANGER: ALCOHOL, DRUGS, SMOKING AND YOUR BABY

One out of every 14 babies born in the U.S. in 1990 was born with a birth defect, according to the March of Dimes. Many of these birth defects could have been prevented.

Pregnant women who use tobacco, alcohol, or other drugs often have nutritional problems as well as other complications that can result in birth defects. There is no better time than when you are pregnant to quit or cut down on harmful habits. Don't worry about past uses; just make sure they are your last.

Here are some important points to keep in mind:

• **Wine, beer and hard liquor can cause serious harm to a growing fetus.** When you drink, your baby drinks. Since nobody knows how much is too much, most experts feel it's best not to drink any alcohol during pregnancy.

• **Illegal drugs, such as marijuana, cocaine, crack, heroin and PCP have all been shown to pose serious health risks to both the pregnant woman and her unborn child.** Even legal drugs can have harmful effects. So avoid all medications except those prescribed by your doctor. This includes drugs that can be bought over the counter.

• **Research has shown that smoking during pregnancy raises the risk of premature delivery, low birthweight and intellectual deficiencies in childhood.** Why? Nicotine constricts uterine blood vessels, decreasing the amount of nutrients and oxygen the fetus receives.

The American Lung Association (ALA) offers a quit-smoking program called "Freedom From Smoking for You and Your Baby" especially designed for pregnant women. The program lays out distinct daily goals for the smoker and stresses the importance of reward whenever a goal is met. It also includes breathing and relaxation exercises to help reduce the stress that often accompanies quitting.

To receive the "Freedom From Smoking for You and Your Baby" step-by-step manual and audio tape (\$8.00 for the set) call your local ALA at: 414-782-7833.

HEALTH PAGES

WHAT IS PRENATAL CARE AND WHY IS IT SO IMPORTANT?

Prenatal care is the term used to refer to regular visits to a doctor, midwife or clinic throughout pregnancy. These checkups help safeguard your health as well as the health and well-being of your baby.

Regular prenatal visits help your doctor or midwife discover and treat or prevent problems such as *anemia* (low levels of iron and oxygen in the blood), *gestational diabetes* (diabetes which only occurs during pregnancy) and *pre-eclampsia* (a potentially dangerous condition signaled by abnormal swelling, high blood pressure and protein in the urine). These and other conditions are often easily corrected when discovered early, but left untreated, they can threaten your health as well as the health and even the life of your baby. The schedule of your prenatal visits will vary, depending on your

practitioner, but usually will include:

1) *An overall physical exam.* This exam is generally done early in pregnancy; it should be scheduled within a week or two of discovering you're pregnant. Your practitioner will confirm your pregnancy, determine the state of your general health and pinpoint any possible problems that need treatment or monitoring.

2) *Regular monthly checkups for the 1st through the 7th month.* Your doctor will listen to the baby's heartbeat and measure your uterus (from the outside) to ensure that your baby is growing normally. He or she will determine whether you are gaining enough weight and will check your blood pressure, test your blood (for anemia) and urine (for sugar and protein), and examine your hands and feet for signs of abnormal swelling (*edema*). This is also when you should alert your doctor to any physical problems you might be having. Be sure to write down any questions before your checkup.

FINDING DOCTOR RIGHT

In order to choose a doctor who is right for you, you need information. A good place to start is the HEALTH PAGES, "Your Guide to Obstetricians" (p. 18) provides specific information about local doctors and their practices.

In addition to checking the listings, ask for referrals from friends and relatives and, if possible, from nurses and other medical personnel. Surveying friends and strangers may not sound terribly scientific, but it's actually a great way to get helpful information you can't get any other way. The more people you talk to, the better. There's no magic number, just keep asking for names until you start hearing the same two or three being highly recommended over and over again.

Some questions you may want to ask people about the doctors they recommend:

- Do you feel confident about his or her medical judgment?
- Does the doctor listen attentively when you tell him or her what's wrong, without interrupting or rushing you?
- Does he or she take enough time to explain the problem and its treatment?
- Is the doctor easy to talk to? Do you feel comfortable discussing small worries or embarrassing problems?
- Is the doctor reachable by phone? Is he or she willing to give simple advice over the telephone?

If a doctor who has been recommended to you is not listed in the HEALTH PAGES and you'd like to double check his or her credentials, contact your local medical society. The staff can tell you about a member's training and area of specialty.

SCHEDULE A "GET-ACQUAINTED" APPOINTMENT

All right. So you've constructed a list of potential doc-

tors based on conversations with friends and medical professionals. You checked out each doctor by learning about him or her through the HEALTH PAGES or your local medical society. You've narrowed the field to one or two candidates. There's one more step you should take to help you reach a final decision—make an appointment to meet with the doctor. (If the doctor does not offer free initial consultations, request an appointment for a short consultation.)

Your evaluation should start before you even step into the doctor's consultation room:

- Is the office staff courteous and helpful when you call? The way the staff treats you often reflects the way the doctor will treat you.

- Do you have to wait long past your scheduled appointment time? Fifteen minutes or more without an explanation is unreasonable.

To get the most out of the meeting, come prepared to discuss your top three health concerns about your pregnancy. Be brief and note the doctor's reactions and comments. Let the doctor know you want to play an active role in your health care. Tell him or her that you want to hear all available options in the event of a problem. Be honest about the kind of doctor-patient relationship you're looking for, and the doctor will usually respond openly as well.

It is tremendously important to like the doctor. If you are not comfortable and/or do not trust or have confidence in the doctor, continue your search. You must be able to confide in your physician. If you can't, you are setting yourself up for poor medical care. Respect is also a critical piece of the formula; if you don't respect your doctor, you will always have doubts about his or her recommendations and you will be less likely to comply with treatment.

HEALTH PAGES

3) *Regular checkups every 2 weeks in the 8th month, once a week in the 9th month, until the baby is born.* Checkups will be similar to earlier exams except that your practitioner will also carefully examine the size and position of the baby as well as check your cervix to see if it is softening or thinning out in preparation for birth. Some practitioners refer to the cervix as "green" when it is firm and "ripe" when it is soft. A soft, "ripe" cervix means the baby will be born soon!

TESTS TO EXPECT DURING PREGNANCY

Experts agree that a woman should begin to undergo routine screening tests either before conception or at her first prenatal visit. These tests alert doctors to potential problems and provide a basis for comparison as the pregnancy progresses. Here are some straightforward answers to questions about the most common tests during pregnancy, their risks and why they are necessary.

FIRST TRIMESTER TESTS

- *Tests for glucose, protein and blood in the urine* to detect problems such as impaired kidney function and diabetes

- *A cervical culture* for gonorrhea and chlamydia

- *Blood tests* to determine blood type and Rh type (to test for Rh incompatibility, which can result in a disease that can be prevented with a vaccine) and to check for anemia

- *Tests for rubella and toxoplasmosis* (a parasitic infection) and hepatitis B

- *Chorionic Villus Sampling (CVS)* can detect defects in the fetus as early as the ninth week of pregnancy. The problem: The possible risk the test poses. Studies conducted in 1992 yielded conflicting results concerning the safety of CVS. Researchers at Michael Reese-Humana Hospital in Chicago found a higher incidence of limb defects in babies born to women who had undergone CVS. However, most other studies, including a later one conducted by researchers at Jefferson Medical College in Philadelphia, found CVS to be safe. Before having CVS, discuss the benefits and risks of the procedure with your doctor, and don't be afraid to request a second opinion.

SECOND TRIMESTER TESTS

- *Ultrasound* (or sonography) is a procedure that can be performed from the fifth week of pregnancy up until delivery, but it is generally done after the sixteenth week. The test uses sound waves to produce a picture of the fetus (sonogram) without the hazards of x-rays. Most ultrasound machines have a TV-like screen that pro-



A SONOGRAM (ultrasound picture) of the publisher's son, Jordan, in the 18th week of his development.

vides parents-to-be a unique opportunity to see their baby. Often they can even get a copy of the sonogram to show to family, friends and their child in later years.

Ultrasound is done for a variety of reasons. If performed early, it can be used to date a pregnancy. Later, it can be used to identify possible causes of a problem such as vaginal bleeding, determine the condition of the placenta, diagnose a multiple pregnancy, determine whether the baby is growing properly and verify breech presentation or another uncommon fetal or cord position prior to delivery.

Although in 25 years of clinical use and study, no harmful effects have been associated with ultrasound, the American College of Obstetricians and Gynecologists (ACOG) still recommends the procedure be performed only when necessary — not on a routine screening basis. Many obstetricians provide ultrasound services in their offices. Check the annex section of "Your Guide to Obstetricians" on p. 58 to see whether your doctor offers ultrasound.

- *Alpha-Fetoprotein (AFP) Screening*, performed between the fifteenth and eighteenth week of pregnancy, analyzes the mother's blood to detect the possibility of abnormalities in the baby's brain or spinal cord or a chromosomal disorder such as Down's syndrome. The problem with the AFP test is the high number of false positives it produces. If you have an AFP screen, remember, it is only a screening test. Any abnormal results require further testing to confirm the existence of a problem. Because the test can detect possibly serious illnesses and poses no danger to the mother or the fetus, experts recommend AFP screening for all pregnant women.

- *Amniocentesis*, usually performed between the fourteenth and eighteenth week of pregnancy, is a diagnostic test that can identify a number of fetal

HEALTH PAGES

problems, including the existence of Down's syndrome and the possibility of Tay-Sachs disease or sickle-cell anemia. Since Down's syndrome is most prevalent among children of older women, amniocentesis is usually recommended for all women over age 35.

How it works: the doctor inserts a slender needle through the abdomen and into the amniotic sac surrounding the fetus to extract fluid for examination. Through chromosome analysis the test can also reveal the sex of the fetus.

THIRD TRIMESTER TESTS

A number of the tests performed earlier, such as those for glucose tolerance, are repeated or updated in the third trimester. If your doctor suspects a problem, he or she may also recommend additional testing.

IT'S TIME: THE DRAMA OF BIRTH

For most new parents childbirth is not a sequence of orderly stages, but rather a blur of new physical and emotional experiences. Emotions seesaw from excitement to apprehension. The more you learn about the process of labor and delivery, the better prepared you'll be. Here's a preview of what to expect.

LABOR: WHAT IS IT?

Make no mistake, as its name implies, labor is hard work. During labor, the muscles of your uterus *contract* (tighten) and relax at increasingly shorter intervals. These contractions cause the cervix, the entrance of the uterus, to *dilate* (open). Once the cervix is fully dilated, the contractions help move the baby through the *birth canal* (vagina).

FIRST STAGE OF LABOR

The first and longest stage of labor is fortunately also the least intense. During this period, which can last many hours, the cervix begins to dilate. Contractions at this stage are usually mild to moderately strong. In most cases there's no need to be at the hospital until contractions increase in intensity and come about five minutes apart.

WHAT WILL HAPPEN AT THE HOSPITAL?

Once you've been admitted to the hospital, your nurse or physician will check your blood pressure, pulse, respiration and temperature, and will listen to your heart and lungs. Your doctor will feel your abdomen to assess the weight and position of the baby, and may do a vaginal examination to learn how much the cervix has dilated. By this time, your cervix probably will have dilated between four and seven centimeters.

Your doctor may also check your baby's heartbeat with a fetal stethoscope or an *external fetal monitor*. The monitor is strapped around the mother's abdomen to record the baby's heartbeat and the pressure of labor contractions. If fetal distress is suspected, the doctor may opt for *internal fetal monitoring*, in which an electrode is inserted through the cervix and attached to the baby's scalp.

EASING LABOR PAINS

Everyone responds differently to discomfort and pain. To combat the pain of labor and delivery, you may find that all you need are your relaxation techniques and the support of the people around you. Or you may feel you need pain relievers.

Although many women believe natural childbirth (in which no drugs are used) is a wonderful experience, you should not feel guilty if you can't or don't want to go through labor without pain relievers. There are a number of medications from which to choose. Some, such as the pain relief-



HEALTH PAGES

er Demerol, are injected. Others, such as Phenergan, which can help reduce anxiety and nausea, are taken orally. An *epidural*, which is a regional anesthetic, blocks sensation from the waist down. Talk to your doctor about each drug's pros and cons.

Transition — This term refers to the final three centimeters of dilation, to a full 10 centimeters. It is the most exhausting and demanding phase of labor. Your coach's support and reassurance will be especially welcome at this time.

SECOND STAGE OF LABOR: HERE COMES THE BABY!

Active labor, or the actual BIRTH of the baby usually lasts about an hour or two for first-time mothers, 30 minutes for women who've given birth before. Pushing is always exciting, and hard as it is, a terrific emotional thrill. In pushing, the woman uses her abdominal muscles to move the baby down the birth canal. Between contractions, when both the uterine and abdominal muscles are relaxed, the baby usually slips back a little. Pushing is a 2 down, 1 back, 2 down, 1 back process until the baby's head starts to *crown*—is visible in the vagina.

If necessary, your doctor will perform an *episiotomy*—an incision that widens the vaginal opening to pre-

vent tearing or to speed delivery—before crowning. A local anesthetic may be administered to numb the area before the cut is made. Stitches will dissolve by themselves a few days after the birth. Whether you need an episiotomy will probably depend upon your skin's elasticity and the baby's size. Find out how your doctor feels about episiotomies before labor begins.

THIRD STAGE OF LABOR: THE "AFTERBIRTH"

This is the shortest stage of labor, usually lasting less than 30 minutes. After the baby is born, you will continue to have mild contractions which will help push out the *afterbirth* (placenta, umbilical cord, and amnion).

While this is happening, your baby will undergo several routine procedures, including weight and height measurements, foot printing, and the administration of silver nitrate eye drops to prevent infection. A nurse will observe the baby's heart rate, breathing, muscle tone, reflexes and color at one and five minutes after delivery and give him or her an Apgar (Appearance, Pulse, Grimace, Activity, Respiration) score. These post birth examinations assess the baby's condition on a scale of zero to 10. Vigorous babies score 7 or higher.

CHILDBIRTH CLASSES 101

The more prepared you are for labor and delivery, the better. That's why many couples take childbirth education classes before the big day. In addition to getting you ready for labor and delivery, childbirth classes offer much needed moral support for parents-to-be. During the emotionally intense months before delivery, it helps to have the camaraderie of people in the same manic/panic state. Often it is in these classes that lifelong friendships are forged.

There are several approaches with varied philosophies from which you can choose. Many instructors combine elements of each in their classes. Lamaze, the most commonly used method, prepares women to cope with the stress of labor and delivery through education and relaxation techniques which include a series of breathing exercises to be used during contractions. Bradley, another popular teaching philosophy, emphasizes the father's role as labor coach. When shopping around for a class, ask your doctor or health care practitioner for recommendations and visit prospective classes to determine what's right for you (see page 24 for some local options).



Cesarean Section: The Most Common Surgical Procedure in the United States

In 1984, Cesarean section (often called a C-section), in which the baby is taken from the womb through an abdominal incision, became the most common operation in the United States. In fact, nearly one out of every four babies in this country — a full 23.5 percent — is delivered via C-section. Since that time

there have been a number of published reports criticizing C-sections as one of the most over-performed procedures. Critics argue that C-sections needlessly risk the mother's life or health without benefit to the baby. But the fact is a Cesarean is called for when a natural vaginal delivery is thought to be hazardous to either the baby's or mother's health.

HOW CAN YOU KNOW IF A CESAREAN IS REALLY NECESSARY?

The more you learn about Cesareans before delivery, the more easily you'll understand and accept the surgery if it becomes necessary. A look at the most frequently given reasons for Cesarean sections will help equip you with information as well as provide you with tips on how you and your caregiver can reduce your chances of needing a Cesarean. Some of those reasons:

1. You have had a previous Cesarean delivery. Up until very recently, if a woman had one Cesarean delivery, her doctor would almost always deliver subsequent children by Cesarean as well. Why? Doctors were concerned that the woman's uterus would rupture during labor. It is now known that the risk of that happening is very small, especially if the uterine incision made during the Cesarean was of the low, horizontal (*low transverse*) rather than vertical type (see figure p. 16). The good news: Many doctors now support the use of *Vaginal Birth After Cesarean* (VBAC) if the mother and baby have no medical problems (see p. 16).

2. Dystocia—When the baby's head is too big to pass through your pelvis or when labor does not progress. Nature, in its wisdom, generally matches the baby's size with that of the mother's uterus. If this is not the case, a Cesarean may be necessary. Much depends on how well you labor. Labor may not progress if the

uterus does not contract as it should. You can improve your contractions by staying relaxed and confident — try the relaxation methods you learned in your childbirth education classes — breathing normally, and experimenting with different birthing positions to help your cervix dilate. Move around as long as you can or try lying on your side. But know that even if

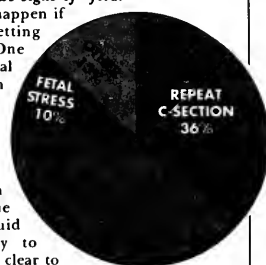
you do your best, a Cesarean may still be necessary. Some physicians will try to give sluggish contractions a boost with *oxytocin* (a drug used to initiate or speed up labor) before resorting to a Cesarean.

3. Breech birth—When the baby's feet or bottom appear first. The usual position of engagement is head-down. But some babies are in the breech position—feet or buttocks first. This makes a vaginal delivery difficult for both mother and child, especially in the case of a first birth or when the baby is premature or very large. Many breech babies turn head down by themselves. Some caregivers may suggest daily exercises to help the baby turn or offer to try to turn the baby before labor starts. Although some caregivers will deliver a breech baby vaginally, most breech babies are delivered by C-section.

4. The baby shows signs of "fetal stress."

This can happen if the baby is not getting enough oxygen. One possible sign of fetal stress is a change in the baby's heart rate. Another sign is a *meconium stain*. This occurs when the baby has a bowel movement in utero, causing the color of the fluid around the baby to change color from clear to green, yellow or brown.

If fetal stress is detected, work with your caregiver



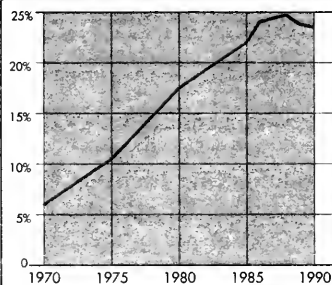
REASONS
FOR C-SECTIONS (1989)

HEALTH PAGES

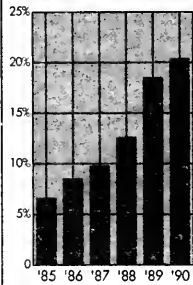
National Rates

As the charts show, after almost two decades of steady growth, the national C-section rate appears to be leveling off. At the same time, the number of Vaginal Births after Cesarean (VBACs) is steadily increasing.

C-SECTION RATES PER HUNDRED BIRTHS



VAGINAL BIRTH AFTER CESAREAN



er to increase the supply of oxygen to the baby. Sometimes fetal stress ceases to be a problem when the mother changes position or is given more intravenous fluid, or when the flow of oxytocin is slowed or stopped. Your caregiver may also want to monitor the baby more closely using continuous internal electronic monitoring or by examining a small drop of blood from the baby's scalp (*fetal blood sampling*). Test results may eliminate the need for a Cesarean delivery.

5. **Maternal medical problems**, such as premature labor, premature rupture of membranes, high blood pressure and diabetes may make a vaginal birth too risky to attempt.

WHAT HAPPENS WHEN A CESAREAN IS NECESSARY?

When a Cesarean is necessary, the mother is usually given a regional anesthetic (such as an epidural), which is injected into the spinal area, to numb the lower body. She is awake and aware of what's happening and the baby's father can usually remain at her side. Nowadays, general anesthesia, which puts the mother to sleep, is typically reserved for complicated or emergency Cesareans.

After the anesthetic is administered, the doctor usually makes a side-to-side incision called a bikini cut in the lower abdomen and a low-transverse incision in the uterus. The obstetrician then punctures the amniotic sac, drains the fluid and lifts out the baby. The time from the first incision to delivery is usually five to ten minutes; closing the cut takes about 45 minutes.

A C-section generally costs \$3,000 more than a vaginal delivery and requires a longer hospital stay —

usually an additional two days. Women may feel greater physical discomfort, including nausea, pain and abdominal gas after a Cesarean birth than after a vaginal birth, and should refrain from strenuous activity for several weeks.

WHY HAVE C-SECTION RATES INCREASED SO DRAMATICALLY?

Technology. The increase in C-sections corresponds to advances in medical technology that enable doctors to detect fetal problems that were undetectable twenty years ago. Consequently, the good news about C-sections is that they are largely responsible for the drop in mortality rates among mothers and their babies—doctors today safely deliver by Cesarean babies who would have otherwise died. That is the medical goal of C-sections.

High malpractice premiums. Malpractice suits against obstetricians have increased dramatically over the last decade. The resulting premium that doctors have to pay (in some cases more than \$100,000 a year) has made physicians more cautious in their practice of medicine. The legal liability associated with difficult vaginal deliveries in which something could go wrong may pressure doctors to perform C-sections more often than is medically necessary. Rarely are doctors sued for performing a C-section when a vaginal delivery would have sufficed.

"Once a C-section, always a C-section." Cesareans may be self-perpetuating. Once a patient has had one C-section, many doctors will routinely perform a Cesarean with subsequent deliveries even when a vaginal birth is possible.

WHAT IS A VBAC AND SHOULD YOU CONSIDER HAVING ONE?

Vaginal Birth After Cesarean involves a trial of labor which results in either a vaginal birth or another C-section.

In 1988, ACOG issued guidelines in an attempt to curtail routine repeat C-sections. The guidelines advise doctors to give women who have previously given birth by C-section the opportunity to let labor progress naturally rather than automatically scheduling a C-section for subsequent births.

In 1990, 20 percent of women who previously had a Cesarean were able to give birth vaginally. That's up from 13 percent in 1988 and less than 4 percent in 1980.

WHAT ARE THE ADVANTAGES OF A VBAC?

1. **Less risk.** A vaginal birth usually results in fewer medical problems for both the mother and the baby than Cesarean birth.

2. **Shorter recovery.** Recovery time for a vaginal birth, both in the hospital and at home, is much shorter than that for a Cesarean birth. Because there's no surgery to recuperate from, a woman generally feels better and can resume her everyday activities sooner. She can also enjoy and care for her baby earlier.

3. **More involvement.** Many women want to be actively involved in childbirth and there's no question that a vaginal delivery allows for greater participation. Also, although most hospitals allow a support person to be present during labor and vaginal birth, the same is not necessarily true for Cesareans, especially if general anesthesia is used.

ARE YOU A CANDIDATE FOR VBAC?

There are a number of issues caregivers must consider when deciding if a woman can have a VBAC. Key

factors that make a VBAC attempt possible:

1. Neither the mother nor the baby has any major medical problems.
2. The health of the mother and baby can be closely supervised during labor. The hospital should be equipped to perform an emergency Cesarean or provide other emergency medical treatment if necessary. Note: The chances of needing an emergency Cesarean are no greater for a woman who has already had one Cesarean than for a woman who previously gave birth vaginally.
3. The incision in the uterus from the previous Cesarean is horizontal.

Our thanks to the following doctors for reviewing this section: C. Irving Meeker, M.D., Maine Medical Center, Portland, ME and Vrunda Patel, M.D., Princeton Medical Center, Princeton, N.J.

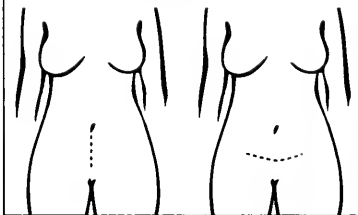
WHAT TO ASK YOUR DOCTOR ABOUT C-SECTIONS

- Are you planning to deliver the baby by Cesarean? Why? Do I have any other alternatives?
- My first baby was delivered through a C-section. Will you let me try a vaginal birth this time?
- If my labor doesn't progress, will you try other procedures, like medication, before performing a C-section?
- If the fetal monitor indicates the baby is in distress, will other methods be used to confirm the monitor's reading before a C-section is performed?

If your doctor has told you that a Cesarean definitely will be necessary, you may want to ask some of the following questions:

- Will the type of incision you make adversely affect my ability to attempt a vaginal delivery with my next child?
- Will the father be able to hold the baby immediately after the birth?
- Can the baby stay in the room with me after the birth?
- How much time will I spend in the hospital for recovery?
- What physical discomfort and limitations can I expect following the surgery?

Incision made in the abdominal wall for Cesarean birth: Classical (left) and transverse (right).



Wisconsin's Cesarean Rates: The Second Lowest in the Nation

A 1992 Public Citizen Health Research Group study of Cesarean rates in 48 states found that in 1990, at 17.5 percent, Wisconsin had the second lowest state Cesarean rate in the United States! In fact, the Wisconsin rate was 26 percent lower than the national average of 23.5 percent. That means 4,200 fewer Cesareans were performed, for a total savings of about \$12,600,000 for Wisconsin consumers.

Wisconsin's VBAC rates are even more encouraging. VBAC rates in Green Bay, Madison and Milwaukee averaged 31 percent—55 percent higher than the national VBAC average of 20 percent.

Clearly, Wisconsin's physicians are leading the way for the rest of the nation when it comes to restraint in the use of Cesarean delivery.

HOSPITAL-SPECIFIC CESAREAN SECTION RATES

The Cesarean rates for hospitals in Wisconsin range from a low of 10 percent to a high of 21 percent (which is still below the national average). One reason a hospital might have a higher Cesarean section rate: If it is set up to serve a high risk pregnancy population.

Neonatal ICU and Level of Care. In most areas of the country *perinatal care* (care for women in the later stages of pregnancy, during labor and delivery and during the first week after delivery) has been regionalized. Very high-risk maternity patients are generally referred to centers with special neonatal intensive care units, which can provide more sophisticated care to sick infants. These patients may be more likely to require a Cesarean delivery, accounting for the hospitals' relatively higher C-section rate.

States designate the perinatal

level of a hospital. Level 3 hospitals handle complicated perinatal cases, Level 2 hospitals handle intermediate cases and all other hospitals that offer maternity services are designated Level 1.

High Risk Pregnancies. If you are over 35, have had a Cesarean section, are having a multiple pregnancy, have a disease such as diabetes, or are at risk for complications such as high blood pressure or obesity, your doctor may classify your pregnancy as high risk. This means you will need additional monitoring, including more frequent ultrasounds and other tests. Depending on why your pregnancy has been classified as high risk, you may or may not be more likely to have a Cesarean delivery. For example, complications resulting from high blood pressure might make a C-section necessary, whereas having had a previous C-section due to failure of labor to progress may not. Remember, many high-risk pregnancies proceed absolutely normally, and result in natural deliveries.

PHYSICIAN-SPECIFIC CESAREAN SECTION RATES

The listing that follows represents the first time in Wisconsin, in fact, in the United States, that physician Cesarean rates are being made available to the public.

When reviewing the tables, bear in mind that a physician's rate may be higher if he or she regularly sees high risk pregnancies or is a consultant to family practitioners.

Family Practice Consultants. In 1989, 27 percent of the deliveries in Wisconsin were performed by family/general practice physicians. Family practitioners actually saw many more pregnancies but often, as the delivery date neared, or during labor, a decision was made to perform a Cesarean, which many hospitals do not allow family practi-

HOW WE COMPILED THE INFORMATION

The HEALTH PAGES requested the Cesarean section rate of every physician in the three metropolitan areas who performed at least 50 deliveries a year in both 1990 and 1991. The state's disclosure laws require that a physician be notified of any information requests and that he or she be given 30 days to review all patient discharge data before it is released. After we received the information, the HEALTH PAGES sent two mailings to every physician listed that included the doctor's C-section rate and number of total deliveries. We asked the doctors to confirm the information and provide us with characteristics about their practices which might affect their rates. The physicians' comments were incorporated into the listings that follow.

HEALTH PAGES

tioners to perform. In those instances, an obstetrician who the family practitioner may regularly consult or one who happens to be on call at the time may be asked to perform the Cesarean, increasing his or her Cesarean rate.

The information in the listings does NOT factor out these additional Cesareans except in a few cases in which the physicians themselves factored out the number of consultant Cesareans they performed and provided us with a separate C-section rate for their own patients.

CESAREAN: THE ROLE OF THE PHYSICIAN

The debate over why Cesareans are performed is heating up and studies are underway throughout the nation. On the local level, Dr. Herbert Sandmire and Dr. Robert DeMott of Ob-Gyn Associates in Green Bay are conducting a multi-year research study, begun in 1986, of busy obstetricians' practices at St. Vincent and Bellin Memorial hospitals.

Their findings thus far: The differences in individual physician Cesarean rates cannot be explained by "patient obstetric risk factors, socioeconomic status, service status, or duration of the physician's prac-

tice...and that...higher Cesarean rates did not result in better neonatal outcome." Instead, the researchers concluded that "individual physician practice style was the only apparent determinant of Cesarean rates for the 11 obstetricians studied. Current Cesarean rates can be substantially reduced without sacrificing fetal and newborn safety" (*American Journal of Obstetrics and Gynecology* 1990; 162:1593-602).

It is because of the role that an individual physician practice style may play in Cesarean delivery that the HEALTH PAGES decided to publish physician-specific C-section rates. After learning about this decision a number of obstetricians and hospital administrators wrote or called our office applauding this effort. Others wondered, sometimes not in the friendliest of ways, why we were doing this.

Our answer: The public has a right to know C-section rates and other information about the health care professionals whose services they pay for. Some doctors may be more likely to perform a Cesarean. Some women who've already had one Cesarean may prefer to have another rather than attempt labor. Ultimately, each woman together with her doctor must choose what's right for her.

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|----------------------|---------------------|----------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|----------------------------|
| Johnson, R.N.T. | | | | | | | |
| Bechtel, Richard Jr. | 1974 | Bellin Mem. | \$1,486 | \$1,796 | 401 | 6% | High Risk |
| Brackman, Michael | 1990 | | 1,633 | 1,904 | 553 | 13% | |
| Cavanaugh, Robert | 1985 | Bellin Mem. | 1,486 | 1,796 | 413 | 8% | High Risk & Infertility |
| DeMott, Robert | 1987 | Bellin Mem. | 1,486 | 1,796 | 391 | 7% | High Risk & Infertility |
| Gallagher, John | 1982 | St. Mary's | | | | *1 | |
| Hallaba, Thomas | 1986 | St. Mary's | | | | *2 | |
| Kincheloe, Thomas | | St. Mary's | | | | *3 | |
| Milbourn, Thomas | | St. Vincent | 1,575 | 2,000 | 319 | 15% | High Risk & Infertility |
| Sandmire, Herbert | 1961&1978 | Bellin Mem. | 1,486 | 1,796 | 434 | 7% | High Risk |
| Schmidke, Amy | | Bellin Mem. | 1,702 | 2,084 | 373 | 9% | High Risk & Infertility |
| Sehring, Frederick | 1967 | | 1,600 | 1,820 | 132 | 15% | |
| Sehring, Stephen | 1991 | St. Vincent | 1,600 | 1,820 | 270 | 13% | High Risk & Infertility |
| Shaffer, Richard | 1979 | | 1,633 | 1,904 | 597 | 13% | |

HEALTH PAGES

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|------------------------|---------------------|----------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|---|
| Utrio, John | 1968 | St. Vincent | \$1,702 | \$2,084 | 270 | 13% | High Risk |
| Vogel, Edward | 1972 | | 1,633 | 1,904 | 615 | 14% | |
| Walleridge, Mary | | | 1,575 | 2,000 | 303 | 13% | |
| MADISON | | | | | | | |
| Anderson, John | 1975 | | 1,383 | 2,045 | 295 | 23% | High Risk |
| Baker, Robert Jr. | 1971 | Meriter | 1,723 | 2,182 | 421 | 17% | |
| Barnard, Gerald | 1991 | Meriter | 1,566 | 1,820 | 239 | 16% | High Risk Only - Referral Required |
| Beck, James | 1967 | | 1,383 | 2,045 | 290 | 23% | High Risk |
| Christmann, Robert | 1971 | | 1,383 | 2,045 | 419 | 22% | High Risk |
| Davidson, Susan | 1989 | St. Mary's | 1,383 | 2,045 | 242 | 23% | Perinatologist-High Risk |
| Demopoulos, Jean | 1986 | St. Mary's | 1,383 | 2,045 | 390 | 20% | High Risk |
| Dien, Klaus | 1980 | Meriter | 1,723 | 2,182 | 332 | 20% | High Risk, Infertility & Endoscopic Surgery |
| Dreite, Sabine | 1992 | Meriter | 1,566 | 1,820 | 176 | 22% | High Risk Only - Referral Required |
| Estrin, Margaret | 1985 | Meriter | 1,490 | 1,938 | 286 | 11% | High Risk |
| Fok, Joseph | 1984 | St. Mary's | 1,383 | 2,045 | 709 | 26% | High Risk, Infertility & Laparoscopy |
| Hockforth-Jones, Jenny | 1988 | Meriter | 1,490 | 1,938 | 218 | 13% | High Risk, Infertility & Adolescents |
| Henderson, Perry | 1970 | Meriter | 1,566 | 1,820 | 248 | 10% | High Risk & Maternal-Fetal Medicine |
| Herzog, Paul | 1971 | Meriter | 1,723 | 2,182 | 386 | 21% | |
| Jackson, C. Robert | 1964 | Meriter | 1,723 | 2,182 | 183 | 19% | |
| Keller, Jr., William | 1979 | St. Mary's | 1,383 | 2,045 | 347 | 22% | High Risk |
| Kronman, Karen | 1987 | St. Mary's | 1,383 | 2,045 | 367 | 26% | High Risk, Laser Laparoscopy & Menopause |
| Landauer, Megan | 1988 | Meriter | 1,723 | 2,182 | 147 | 28% | Perinatologist - High Risk |
| McLeod, Paul | 1969 | Meriter | 1,723 | 2,182 | 283 | 25% | |
| Miller, Kim | 1989 | Meriter | 1,723 | 2,182 | 328 | 20% | |
| Roley, Everett | 1966 | | 1,383 | 2,045 | 320 | 36% | High Risk Patients |
| Roley, Kevin | | St. Mary's | 1,383 | 2,045 | 210 | *5 | High Risk, Family Practice Referral & Infertility |

*1 The state's information on Dr. Gallagher's practice listed a C-section rate of 22% and 403 deliveries. St. Mary's hospital wrote us that Dr. Gallagher had performed 282 deliveries with a C-section rate of 23%. When his family practice consultant C-section rate is factored out, his C-section rate with his own patients is 17%.

*2 The state's information on Dr. Hallain's practice listed a C-section rate of 23% and 503 deliveries. St. Mary's hospital wrote us that Dr. Hallain had performed 313 deliveries with a C-section rate of 22%. When his family practice consultant C-section rate is factored out, his C-section rate with his own patients is 14%.

*3 The state's information on Dr. Kincheloe's practice listed a C-section rate of 17% and 447 deliveries. St. Mary's hospital wrote us that Dr. Kincheloe had performed 314 deliveries with a C-section rate of

15%. When his family practice consultant C-section rate is factored out, his C-section rate with his own patients is 10%. In addition Dr. Kincheloe wrote us that his C-section rate was 12% (July 1990-June 1992); after adjusting for consultant C-sections that rate falls to 8-9%.

*4 St. Mary's Hospital asked us to print the following sentence: "This percentage figure includes an unknown number of emergency Cesarean sections performed at the request of family physicians who deliver at his/her hospital and does not reflect the Cesarean section rate on patients followed throughout pregnancy by this obstetrician."

*5 The state provided the HEALTH PAGES with a 31% C-section rate. Dr. Roley adds that during the period of July 1, 1991 to June 30, 1992 his primary C-section rate (excluding women who previously had a Cesarean) was 21%. Dr. Roley is Board Certification Eligible.

HEALTH PAGES

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|-----------------------|---------------------|------------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|---|
| Rodet, Karl | 1979 | | \$1,383 | \$2,045 | 716 | 13% | High Risk |
| Rodman, Sherwin | 1980 | Mariter | 1,723 | 2,182 | 263 | 19% | |
| Shay, Gerald | 1977 | | 1,383 | 2,045 | 308 | 23% | High Risk |
| Tarburst, James | 1977 | | 1,383 | 2,045 | 261 | 26% | High Risk |
| Alman, Edward | 1976 | | | | 128 | 19% | |
| Alexander, A. Charles | 1978&1989 | St. Luke's-Racine | 1,820 | 2,195 | 533 | 14% | Cervical Dysplasia |
| Alexander, Janice | 1991 | St. Joseph's | 1,650 | 1,874 | 187 | *6 | High Risk, Infertility & Family Practice Consultant |
| Angston, Beth | 1988 | | 1,728 | 2,050 | 295 | 13% | |
| Azceta, Ester | | | | | 239 | 14% | |
| Babbitz, Allen | 1976 | St. Mary's | 1,700 | 2,000 | 131 | 14% | |
| Bacrus, Donald | 1982 | St. Joseph's | 1,750 | 1,980 | 389 | 20% | High Risk |
| Bae, H. Hak | 1973 | St. Luke's - Milwaukee | 1,800 | 2,200 | 199 | 37% | High Risk & Family Practice Consultant |
| Bahal, Rajinder | 1977 | | 1,600 | 1,800 | 131 | 26% | |
| Barr, Carmelo | 1985 | | 1,800 | 2,200 | 125 | 25% | |
| Beal, Brian | 1991 | | 1,750 | 1,980 | 539 | 13% | |
| Bellis, David | | | 1,600 | 2,000 | 168 | 18% | |
| Bharthara, Dhru | 1983 | | 1,800 | 2,250 | 321 | 20% | |
| Bines, Milton | | | 1,765 | 2,205 | 163 | 17% | |
| Bodner, Aaron | 1974 | | 1,500 | 1,700 | 721 | 9% | |
| Borkawf, Harold | 1972 | | 1,980 | 2,310 | 285 | 14% | |
| Boyce, Lorenzo | 1988 | St. Luke's - Racine | 1,701 | 2,122 | 463 | 15% | |
| Brennan, John | 1957 | St. Joseph's | 1,630 | 2,020 | 597 | 14% | High Risk, Infertility & Natural Family Planning |
| Brockman, Lenora | 1987 | St. Luke's-Racine | 1,701 | 2,122 | 570 | 14% | |
| Brookhouser, Fredrick | 1981 | Sinai Samaritan | 1,550 | 1,450 | 354 | 12% | High Risk & Maternal-Fetal Specialist |
| Budarape, Suseela | 1985 | | 1,800 | 2,000 | 387 | 14% | |
| Burch, Kim | 1982 | Community Mem. | 1,769 | 2,220 | 360 | 16% | High Risk |
| Berstein, Paul | 1979 | St. Mary's | 1,700 | 2,000 | 188 | 17% | High Risk |
| Castillo, Marcelo | 1972 | Sinai Samaritan | 1,550 | 1,450 | 350 | 12% | |
| Chambers, LeRoyce | 1980 | West Allis Mem. | 1,665 | 1,975 | 274 | *7 | High Risk & Infertility |

*6 The state's information on Dr. Alexander's practice listed a C-section rate of 34%. Dr. Alexander wrote us that her C-section rate with her own patients, excluding referral patients, was 21%.

*7 The state's information on Dr. Chambers' practice listed a C-section rate of 50%. Dr. Chambers wrote us that his "true C-section rate is around 17%" when you factor in his role as a high risk pregnancy consultant for family practice doctors for the HMO, Family Health Plan.

HEALTH PAGES

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|----------------------|---------------------|----------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|--|
| Clark, Douglas | 1968 | Community Mem. | \$1,769 | \$2,220 | 258 | 10% | High Risk & Infertility |
| Claude, John | 1962 & 1978 | Oconomowoc | 1,650 | 2,000 | 154 | 32% | |
| Coulter, Renee | 1986 | | 1,800 | 2,060 | 350 | 19% | |
| Craft, Samuel | 1985 | St. Luke's-Milw. | 1,800 | 2,250 | 364 | 14% | Endoscopy & Minimally Invasive Surgery |
| Deloiden, James | 1975 | Waukesha Mem. | 1,800 | 2,250 | 238 | 16% | High Risk |
| Darling, Raymon | 1986 | | | | 490 | 9% | |
| Decker, Mark | 1991 | St. Joseph's | 1,675 | 2,440 | 369 | 8% | High Risk, Infertility & Laparoscopy |
| Diablo, Lynn Kaitter | 1980 | Elmbrook Mem. | 1,728 | 2,050 | 290 | 17% | High Risk |
| Dolan, James | 1979 | West Allis Mem. | 1,750 | 2,050 | 226 | 15% ⁹ | High Risk, Infertility, Laparoscopy & Hysteroscopy |
| Dvoracek, Francine | 1988 | | 1,900 | 2,100 | 137 | 16% | |
| Earle, Sandra H. | | St. Mary's | 1,900 | 2,100 | 259 | 8% | High Risk |
| Eiche, Jocelyn | 1989 | | 1,680 | 1,970 | 309 | 18% | |
| Falt, Gary | 1990 | Columbia | 1,650 | 2,200 | 554 | 15% ¹⁰ | |
| Finlayson, William | 1962 | | 1,680 | 1,890 | 399 | 12% | |
| Fox, Brian | 1986 | St. Luke's-Racine | 1,785 | 2,336 | 449 | 12% | |
| Fritz, Robert | 1965 | | 1,800 | 2,000 | 259 | 19% | |
| Guray, Fann | | | | | 352 | 8% | |
| Gilman D.O., Daniel | 1991 | Sinai Samaritan | 1,600 | 1,950 | 360 | 11% | Infertility & Obstetric Care |
| Gilman D.O., Michael | 1987 | | 1,654 | 1,864 | 267 | 18% | |
| Gondi, Jyothi | 1984 | St. Michael's | 1,654 | 1,864 | 179 | 41% | High Risk |
| Gradese, Elena | 1986 | | | | 280 | 17% | |
| Gryniewicz, Michael | 1973 | St. Joseph | 1,680 | 1,970 | 251 | 11% | High Risk |
| Gustin, Alan | 1980 | Oconomowoc | 1,650 | 2,000 | 244 | 23% | |
| Hamdrick, Thomas | 1970 & 1978 | Columbia | 1,800 | 2,060 | 327 | 19% | High Risk & Infertility |
| Hayes, James | | | 1,800 | 2,200 | 286 | 24% | |
| Heitman, Timothy | 1989 | St. Luke's-Milw. | 1,600 | 1,900 | 286 | 13% | High Risk |
| Hofbauer, Thomas | 1966 | | 1,769 | 2,220 | 231 | 10% | |
| James, Janice | 1986 | Sinai Samaritan | 2,270 | 2,841 | 280 | 13% | High Risk, Maternal-Fetal Specialist & Prof Gynec. |

*8 The state's information on Dr. Decker's practice listed a C-section rate of 23%. Dr. Decker wrote us that in 1990-91 he received high risk referrals from 11 family practice doctors who do not perform C-sections. In addition, his primary C-section rate was 8% in 1991 and 5% in the first half of 1992. He also stated that he is "a strong proponent of vaginal birth after C-section (VBAC), twin deliveries vaginally and breech deliveries vaginally."

*9 Dr. Dolan provided the following information: Primary C-section rate of 12% and a VBAC rate of 43%.

*10 Dr. Falt provided the following information: His C-section rate with his own patients was 10%; the 15% number includes C-sections on consults.

*11 The state's information on Dr. Gryniewicz's practice listed a C-section rate of 26%. Dr. Gryniewicz wrote us that his practice includes consulting to family practitioners for high risk pregnancies. Consequently, with his own patients his total C-section rate was only 18.6%.

HEALTH PAGES

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|--------------------|---------------------|----------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|---|
| Jirak, George | 1987 | | | | 191 | 26% | |
| Kaminski, Henry | 1989 | Community Mem. | \$1,675 | \$2,012 | 442 | 15% | High Risk, Infertility & Laser Surgery |
| Klueger, Jack | 1954 | | 1,600 | 1,850 | 515 | 16% | |
| Kuhlmann, Randall | | | | | 157 | 27% | |
| Kuhn, Michael Jr. | 1966 | St. Joseph's | 1,700 | 2,000 | 302 | *12 | High Risk, Pelviscopy & Vaginal Surgery |
| LaBranche, Janice | 1989 | St. Luke's-Racine | 1,701 | 2,122 | 494 | 9% | |
| Lalich, Roger | | Waukesha Mem. | 1,850 | 2,419 | 207 | *13 | |
| Lamping, Barbara | | | 1,650 | 2,025 | 145 | 12% | |
| Lawrence, Rebecca | 1991 | | 1,680 | 1,970 | 304 | 18% | |
| LeCloux, David | 1977 | St. Luke's-Racine | 1,785 | 2,336 | 499 | 16% | |
| Lee, Glenda | 1990 | | 1,650 | 2,025 | 183 | 21% | |
| Linn, James | 1986 | St. Mary's | 1,687 | 1,947 | 552 | 13% | High Risk & Family Practice Consultant |
| Loatak, Emilio | | | 1,550 | 1,900 | 274 | 9% | |
| Lucca, Paul | 1979&1989 | Columbia | 1,800 | 2,060 | 263 | 15% | High Risk, Infertility & Menopause |
| Macak, James | | | 1,720 | 2,150 | 149 | 25% | |
| Majewski, Michael | 1985 | Burlington Mem. | 1,700 | | 342 | 19% | |
| Maker, George | 1982 | Burlington Mem. | 1,696 | 2,179 | 287 | 17% | High Risk |
| Mathews, Richard | 1969 | | 1,687 | 1,947 | 353 | 16% | |
| Melnyczko, Walter | | | 1,440 | 1,800 | 239 | 19% | |
| Metzger, Joanne | | | 1,750 | 1,980 | 600 | 18% | |
| Meyer, Matthew | 1977 | Waukesha Mem. | 1,850 | 2,419 | 473 | *14 | High Risk, Infertility & Minimal Invasive Surgery |
| Millan, Alfredo | | Sinai Samaritan | 1,400 | 1,680 | 1064 | 20% | |
| Miller, Dennis | 1991 | | 1,675 | 2,012 | 257 | 19% | |
| Miller, Donald Jr. | 1983 | St. Luke's-Racine | 1,695 | 2,050 | 348 | 15% | |
| Mondloch, Victoria | 1991 | | 1,800 | 2,250 | 386 | 16% | |
| Masson, Jeffrey | 1983 | St. Luke's-Racine | 1,785 | 2,336 | 283 | 14% | High Risk & Male and Female Infertility |
| Myers, Robert | | | | | 155 | 22% | |
| Nash, David | 1982 | St. Mary's | 1,700 | 2,000 | 161 | 11% | |
| Nohl, James | | Waukesha Mem. | 1,769 | 2,220 | 228 | 19% | High Risk |

*12 The state's information on Dr. Kuhn's practice listed a C-section rate of 26%. Dr. Kuhn wrote us that his C-section rate was 20%.

*13 The state's information on Dr. Lalich's practice listed a C-section rate of 23%. Dr. Lalich wrote us that his practice includes consulting to a large number of family practitioners for high risk pregnancies. Consequently, with his own patients his total C-section rate is only

14.5% and his primary C-section rate is 11%.

*14 The state's information on Dr. Meyer's practice listed a C-section rate of 19%. Dr. Meyer wrote us that his practice includes consulting to a large number of family practitioners for high risk pregnancies. Consequently, with his own patients his total C-section rate is only 14.5% and his primary C-section rate is 11%.

HEALTH PAGES

| Doctor | Board Certification | Hospital Affiliation | Vaginal Delivery Price (1992) | Cesarean Section Price (1992) | Number of Deliveries (1990-91) | Cesarean Section Rate (1990-91) | Comments/Special Interests |
|-------------------------|---------------------|----------------------|-------------------------------|-------------------------------|--------------------------------|---------------------------------|---|
| O'Reilly, Julie | 1989 | | \$1,800 | \$2,200 | 234 | 22% | |
| Papadatos, Anthony | 1970 & 1978 | St. Luke's-Milw | 1,800 | 2,200 | 147 | 33% | High Risk & Consultant for St. Luke Family Practice |
| Parson, Jazmin | 1974 | | 1,700 | 2,000 | 317 | 11% | |
| Parker, Edward | 1970 | West Allis Mem. | 1,750 | 2,050 | 273 | 19% | High Risk, Infertility & Laparoscopy |
| Parker, Waymon | | | 1,400 | 1,600 | 382 | 19% ^{*15} | |
| Parillo, Roland | 1970 | | | | 107 | 21% | |
| Pelland, Philip | 1968 | | 1,650 | 2,050 | 212 | 16% | |
| Pirou, Richard Adam | 1991 | St. Joseph's | 2,500 | 2,500 | 325 | 34% | Maternal-Fetal Specialist & High Risk |
| Poremski, Ted | 1982 | | 1,680 | 1,970 | 394 | 22% | |
| Risoud, Anne | 1983 | | 1,945 | 2,450 | 228 | 18% | |
| Rogers, John | | | 1,830 | 2,200 | 235 | 32% | |
| Shawder, Thomas | 1967 | Oconomowoc | 1,650 | 2,000 | 254 | 19% | |
| Shafi, Mohammad | 1975 | Sinai Samaritan | 1,580 | 1,942 | 926 | ^{*16} | High Risk |
| Sirin, Karim | 1974 | St. Francis | 1,600 | 2,000 | 369 | 18% | High Risk |
| Stadler, James II | 1980 | | 1,680 | 2,020 | 550 | 17% | |
| Stewart, William | 1970 | | 1,680 | 1,970 | 376 | 17% | |
| Sturino, Kathy | 1989 | Waukesha Mem. | 1,728 | 2,050 | 252 | 16% | High Risk, Infertility & Laparoscopy |
| Urkakis, Kenneth | 1967 | | 1,800 | 2,300 | 264 | 14% | |
| Vitman, Gerald | 1980 | | 1,800 | 2,060 | 246 | 13% | |
| Vondrak, Ben Frank | 1968 | | 1,775 | 2,275 | 242 | 52% | |
| Waeltz, John Lee | 1989 | | 1,650 | 2,200 | 253 | 9% | |
| Wirth, Robert | 1974 | | 1,800 | 2,250 | 232 | 11% | |
| Washington, Janie Marie | 1989 | Sinai-Samaritan | 1,995 | 2,250 | 269 | 15% | |
| Wetzlar, Robert | 1972 | St. Francis | 1,800 | 2,000 | 134 | 19% | |
| Wlaczynski, Joseph | | St. Luke's-Racine | 1,785 | 2,336 | 402 | 13% | |
| Worthington, Donald | 1977 | St. Joseph's | 2,500 | 2,500 | 426 | 34% | Maternal-Fetal Specialist & High Risk |
| Yollick, Clyde | 1968 | | 1,687 | 1,947 | 265 | 14% | |
| | | | | | | | |
| Lavens, Richard | 1983 | Waukesha Mem. | 1,461 | | 136 | 2% | Family-Oriented Health Care |
| Ramola, Pedro | 1977 & 1984 | Sinai Samaritan | 1,250 | N/A | 573 | 0% | |
| Stevens, Robert | 1987 | St. Vincent | 1,285 | N/A | 114 | 0% | |

^{*15} Dr. Parker provided the following information: Primary C-section rate of 10% and a VBAC rate of 44%.

^{*16} The state's information on Dr. Shafi's practice listed a C-section rate of

21%. Dr. Shafi wrote us that for the period of July 1, 1991-June 30, 1992, his primary C-section rate was 7% and his repeat C-section rate was 8%, for a total C-section rate of 15%.

HEALTH PAGES

HOSPITAL
MATERNITY SERVICES

Women have many options today when it comes to where and how to birth their babies. So, hospitals have begun competing with one another for maternity patients. This has resulted in modernized delivery facilities as well as a greater variety of services from which women can choose. Improvements have come on many fronts, including the number of times a woman is shuffled from room to room during labor, delivery and recovery; the decor in labor and delivery rooms; the flexibility afforded fathers in terms of visiting hours (all the hospitals surveyed allow fathers to visit anytime); the ability to have the newborn spend time after delivery with his or her parents; and the authorization of midwives to deliver babies.

HOSPITAL CLASSES

A valuable education resource

All hospitals offer classes to help new mothers and their families prepare for the proper care of their new arrival. Most of the hospitals listed offer valuable classes in:

- Baby Care
- Breastfeeding
- Infant Nutrition
- Infant CPR
- Sibling Preparation

In addition, some hospitals also offer special classes for single parents (St. Vincent, St. Mary's-Madison), adoptive parents (St. Mary's-Madison, Menomonee Falls) and grandparents (Bellin, St. Mary's-Madison). Meriter, Columbia and St. Francis hospitals have sup-

| Hospital | Type of Class Offered | Average Class Size (Couples) | Number of Meetings | Cost |
|--|-----------------------|------------------------------|--------------------|------|
| Bellin Memorial Hospital | Lamaze | 8 | 4 | \$28 |
| St. Mary's Hospital Medical Center | Lamaze | 7 | 6 | 40 |
| St. Vincent Hospital | Lamaze | 8 | 6 | 40 |
| St. Mary's Hospital Medical Center - Madison | Lamaze | 9 | 6 | 60 |
| Meriter Hospital | Lamaze | 10 | 6 | 60 |
| Burlington Memorial Hospital | Combination | 17 | 5 | 40 |
| Columbia Hospital | ICEA | 12 | 7 | 40 |
| Menomonee Falls-Community Memorial | Combination | 15 | 6 | 35 |
| Milwaukee County Medical Complex Hospital | | | | |
| Oconomowoc Memorial Hospital | Combination | 8 | 6 | 35 |
| St. Francis Hospital | Lamaze | 9 | 6 | 35 |
| St. Luke's Medical Center - Milwaukee | Lamaze | 10 | 6 | 40 |
| St. Luke's Memorial-Racine | Other | 12 | 3 | |
| St. Mary's Hospital | Other | 15 | 6 | 50 |
| St. Michael | Other | 12 | 4 | 40 |
| Shed-Sunartum Medical Center | ICEA | 10 | 9 | 45 |
| Waukesha Memorial Hospital | Lamaze | 9 | 6 | 30 |
| West Allis Memorial Hospital | Other | 20 | 4 | 20 |

CIRCUMCISION
DECISIONShould you circumcise
a newborn son?

Circumcision is the surgical removal of the foreskin from the penis. Although for many people the procedure is an important religious ritual, it is not without risk and is usually not considered medically necessary. Consequently, the circumcision debate goes on.

PRO Some studies have shown that circumcised males have a lower risk of urinary-tract infections than uncircumcised males because their penises collect fewer bacteria and are easier to clean.

CON. Critics of the procedure argue that it is unnecessary—that proper hygiene can be taught, and that the benefits of circumcision don't outweigh the risks associated with any surgical procedure.

Discuss the risks and benefits of circumcision with your doctor and your family. If you decide to have your son circumcised, tell your doctor soon after the baby is born. That way, if you choose, the procedure can be done in the hospital. You will have to sign a permission slip, and pay an additional fee (see chart on p. 27).

Many hospitals offer "refresher" classes for the second time around. A special teenage childbirth class is available at St. Vincent's Hospital.

HEALTH PAGES

port groups for new mothers. St. Luke's offers a special four-hour class on VBAC for \$20 and an Infant CPR class in Spanish. St. Michael's will arrange for interpretation of some of its classes.

GETTING THE MOST OUT OF YOUR HOSPITAL STAY

Bonding. Anyone? Bonding time is the period immediately following the birth (after the baby has undergone preliminary tests) when mother and father can cuddle and caress their newborn without any intrusions. All of the hospitals listed set aside a minimum of 60 minutes for bonding. Many allow for a longer bonding period.

Calling All Coaches. All the hospitals listed allow the presence of at least one coach during delivery. In fact, many hospitals allow more than one loved one to help you through childbirth. Check with your hospital to see if prior arrangements are necessary.

Bring the Cameras — Better Yet, the Video Recorder. All the hospitals listed allow you to record the birth on your own equipment.

Special Roommate. After the birth, many mothers opt to have the baby stay with them at all times. This is called *rooming-in*. Having the baby in the same room makes it easier for a new mother to breastfeed and to respond directly to her baby's needs. (All the hospitals listed allow rooming-in). The down side: A woman whose baby rooms with her may forfeit a large chunk of much needed sleep and rest time.

TERMS IN THE TABLE

Here are definitions for some of the terms that appear in the table on the following page.

Genetic Counseling: Genetic counseling can help a couple determine their chances of having a child with an inherited genetic disorder and make informed choices based on what they find out. A complete history of the couple's family health is taken and the couple must fill out a form listing diseases that may have occurred in their families or that are common to people of their ethnic backgrounds. This is done to find out whether any specific type of prenatal testing should be offered. Lab tests may also be performed at the first counseling session. The risks of having a child with a genetic disorder, which often are lower than the couple may have feared, are explained and the couple's concerns are discussed.

IVF: In vitro fertilization, or IVF, brings a man's sperm and a woman's egg together outside the woman's body. To achieve in vitro pregnancy, couples

should be prepared to invest much time and money, knowing that the chances of success are low. **How IVF works:** The woman is given a combination of hormonal drugs—usually Clomid and Pergonal—to stimulate the ovaries to produce eggs. The eggs are usually retrieved through the vagina and then fertilized with sperm from the woman's partner or a donor. The fertilized eggs are then transferred into the uterus, and if they implant, a pregnancy ensues.

Labor/Delivery/Recovery Room (LDR): The newest trend in hospital maternity facilities, this all-in-one birthing room can accommodate high-, low- and normal-risk pregnancies. Since women who give birth in these rooms are not moved from labor to delivery room once the birth is imminent, LDRs make for a more settling and less disruptive birth experience.

Labor/Delivery/Recovery/Postpartum Room (LDRP): Like the LDR this type of room is becoming increasingly popular in hospitals nationwide. Here, patients not only labor, deliver and recover in one room, but also remain there until they are discharged.

HOSPITAL & LAB AFP PRICES

Alpha-Fetoprotein screening is a blood test usually performed between the 15th and 18th week of pregnancy.

| MILWAUKEE | Medical Science | \$38 |
|---------------------------|---------------------|------|
| Trinity Memorial | Metpath | 76 |
| St. Joseph's Hospital | Roche | 62 |
| St. Francis Hospital | SmithKline | 92 |
| Northwest General | General Medical | 47 |
| Milwaukee County Medical | MML Health Services | 53 |
| St. Mary's Hospital | GREEN BAY | |
| West Allis Memorial | Bellin Hospital | 61 |
| Lakeview Hospital | St. Mary's Hospital | 58 |
| Waukesha Memorial | St. Vincent | 50 |
| St. Luke's Medical Center | MADISON | |
| Elmbrook Memorial | Mariner-General Med | 40 |
| Columbia | St. Mary's Hospital | 34 |
| Froedtert Hospital | University of WI | 43 |
| St. Mary's-Ozaukee | | |
| Community Memorial | | |
| St. Michael's Hospital | | |
| COMMERCIAL LABS | | |
| Bayshore | | 50 |
| Damon | | 113 |

HEALTH PAGES

| | Neonatal ICU | Genetic Counseling | In Vitro Fertilization | LDR/LDRP Rooms | Labor Rooms | Delivery Rooms | Private Rooms | Semi-Private Rooms | Visiting Hours | |
|---|--------------|--------------------|------------------------|-----------------------|-------------|----------------|---------------|--------------------|-------------------------------|-------------------------------|
| | | | | | | | | | Siblings | Other |
| Bella Memorial Hospital | No | No | No | 6 (LDR) | 1 | 0 | 15 | 0 | Unlimited | 2PM - 4PM 6PM - 8PM |
| St. Mary's Hospital Medical Center - Green Bay | No | No | No | 12 (LDRP) | 0 | 0 | 12 | 0 | Unlimited | 11AM - 8PM |
| St. Vincent Hospital | Yes (3) | Yes | No | 8 (LDR) | 0 | 0 | 14 | 7 | 11AM - 8PM | 11AM - 8PM |
| St. Mary's Hospital Medical Center - Madison | Yes (3) | Yes | No | 9 (LDR) | 0 | 2 | 11 | 11 | Unlimited | Noon - 8PM |
| Mariter Hospital | Yes (3) | Yes | No | 26 (LDRP) | 0 | 0 | 8 | 10 | Unlimited | Unlimited |
| Burlington Memorial Hospital | No | No | No | 4 (LDR) | 1 | 0 | 8 | 0 | 11AM - 8 PM | 2PM - 3:30PM 7PM - 8PM |
| Columbia Hospital | Yes (2) | Yes | Yes | 5 (LDR) | 0 | 2 | 4 | 8 | Unlimited | 2:30PM - 4PM 7PM - 8 PM |
| Menomonee Falls- Community Memorial | No | No | No | 3 (LDR) 4 (LDRP) | 0 | 0 | 8 | 0 | Unlimited | Unlimited |
| Milwaukee County Medical Complex Hospital | Yes (3) | Yes | Yes | 4 (LDR) | 0 | 3 | 6 | 9 | 2:30PM - 4PM 6:30PM - 8 PM | 2:30PM - 4PM 6:30PM - 8 PM |
| Oconomowoc- Memorial Hospital | No | No | No | 4 (LDR) | 0 | 0 | 6 | 3 | Unlimited | 2PM - 4PM 7PM - 8PM |
| St. Francis Hospital | Yes (2) | Yes | No | 4 (LDR) | 2 | 3 | 27 | 0 | Unlimited | 2:30 - 3:30PM 7PM - 8PM |
| St. Luke's Medical Center - Milwaukee | Yes (2) | Yes | Yes | 16 (LDRP) | 0 | 1 | 0 | 0 | Unlimited | Unlimited |
| St. Luke's Memorial-Racine | Yes (2) | No | No | 4 (LDR) | 6 | 6 | 11 | 9 | 11AM - 8PM | 11AM - 8 PM |
| St. Mary's Hospital - Milwaukee | Yes (3) | | | 8 (LDR) | 0 | 2 | 21 | 2 | Unlimited | 2PM - 3PM 7 - 8PM |
| St. Michael Hospital | No (2) | No | No | 5 (LDR) | 1 | 2 | 15 | 0 | 10AM - 10PM | 2PM - 8PM |
| St. Michael's Medical Center | Yes (3) | Yes | Yes | 12 (LDR) 24 (LDRP) | 0 | 4 | 4 | 0 | Flexible | 11AM - 8PM |
| Waukesha Memorial Hospital | Yes (2.5) | Yes | Yes | 26 (LDRP) | 0 | 0 | 0 | 0 | Unlimited | 11AM - 8:30PM |
| West Allis Memorial Hospital | Yes (2) | Yes | No | 8 (LDR) | 0 | 3 | 24 | 0 | 9:30 AM - 9:30 PM | 11AM - 8PM |

C-SECTION & VBAC HOSPITAL RATES & PRICES

(1991 figures — 400 patients minimum for inclusion in chart)

| | Total Deliveries | Cesarean Section Rate | VBAC Rate (1990) | Vaginal Childbirth Price* | Cesarean Section Price* |
|------------------------------------|------------------|-----------------------|------------------|---------------------------|-------------------------|
| GREEN BAY | 3,973 | 12% | 36% | | |
| Bella Memorial | 1,397 | 10 | 40 | \$1,400 | \$3,485 |
| St. Mary's | 736 | 15 | 38 | 1,378 | 3,493 |
| St. Vincent | 1,845 | 13 | 36 | 1,543 | 3,297 |
| MADISON | 3,074 | 16% | 35% | | |
| Martha | 3,045 | 16 | 38 | 1,763 | 5,120 |
| St. Mary's | 3,029 | 15 | 31 | 1,604 | 3,415 |
| MILWAUKEE | 25,310 | 15% | 30% | | |
| Burlington-Memorial | 592 | 14 | 47 | 1,589 | 4,131 |
| Columbia | 1,031 | 18 | 32 | 2,457 | 5,075 |
| Embros Memorial-Brookfield | 835 | 17 | 19 | 2,307 | 4,284 |
| Menomonie Falls-Community Memorial | 985 | 11 | 35 | 1,981 | 3,724 |
| Milwaukee County Medical | 751 | 16 | 43 | 2,816 | 7,694 |
| Oconomowoc-Memorial | 488 | 21 | | 1,761 | 4,106 |
| St. Francis | 1,593 | 18 | 16 | 2,138 | 3,879 |
| St. Joseph's | 3,789 | 19 | 20 | 2,392 | 5,182 |
| St. Luke's-Milwaukee | 1,021 | 19 | 44 | 1,966 | 5,664 |
| St. Luke's-Racine | 2,289 | 14 | 44 | 2,200 | 3,997 |
| St. Mary's-Milwaukee | 2,641 | 12 | 38 | 1,967 | 4,407 |
| St. Michael | 1,056 | 13 | 41 | 2,284 | 5,046 |
| Sinal Samaritan | 4,698 | 13 | 28 | 2,409 | 5,625 |
| Waukesha Memorial | 1,638 | 15 | 35 | 1,862 | 4,217 |
| West Allis Memorial | 1,840 | 18 | 27 | 1,740 | 3,616 |
| TOTAL/AVERAGE | 35,372 | 15% | 31% | 1,978 | 4,421 |

The C-section rates for Green Bay, Madison and Milwaukee fall well below the national average, while their VBAC rates are well above it.



*This does not include the fee for the baby (healthy, with no complications) which ranges from \$500-\$800.

Prostate Alert

As a man ages, his prostate, the cluster of glands responsible for the production of semen, gradually grows larger. Although this enlargement is a natural part of the aging process and generally harmless, sometimes it can indicate a serious problem. That's why it is important for every

man over 40 to learn about his prostate—what's normal, what's not, how to detect a problem and how to treat it. Here's what you need to know now in order to prevent trouble later.

HOW COMMON ARE PROSTATE PROBLEMS?

Fairly common. Around the age of 50 about half of all men develop prostate problems resulting from the way the prostate grows. Common complaints:

- A need to urinate frequently, especially at night
- Difficulty starting urination or holding it back
- Inability to urinate
- Weak or interrupted urine flow
- Pain or burning during urination

If you are experiencing any of these symptoms, see your physician without delay. Chances are you simply have an enlarged prostate, or *benign prostatic hypertrophy* (BPH).

In BPH, as the prostate grows larger, it pushes against the urethra and bladder, blocking the normal flow of urine. This condition occurs in 10 million American men. In fact, more than half of men in the United States between the ages of 60 and 70 and as many as 90 percent of men between the ages of 70 and 90 exhibit symptoms of BPH. Although the condition is not life threatening, it can result in urinary tract infection and blood in the urine, and should be taken seriously. Treatment may be required to relieve symptoms.

Sometimes, though, the symptoms listed above signal a more serious problem such as cancer. Only your doctor can tell for sure.

WHAT ARE THE MOST COMMON TREATMENT OPTIONS FOR AN ENLARGED PROSTATE?

In most instances, symptoms resulting from prostate enlargement develop slowly. Although some

men (such as those who have had bladder or kidney damage, repeated urinary tract infections or episodes of acute urinary retention) require surgery, for the majority of men, the discomfort, risk and recovery period associated with surgery must be weighed against its probable benefits.

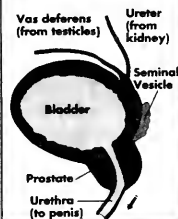
There is usually no need to rush into surgery simply because your symptoms are annoying. Indeed, one alternative to surgery is "watchful waiting." Living with the symptoms to see if they stabilize over time and become less bothersome on their own. If this is not the case and symptoms worsen, surgery is still an option. It is important to remember, though, that the risks of surgery increase as a patient ages and possibly develops other medical problems.

Surgery: The most common surgical treatment for BPH is *transurethral resection of the prostate*, or TURP, in which the doctor trims away excess prostate tissue using a tiny instrument inserted through the penis. A post-surgery hospital stay of two to three days is commonly required.

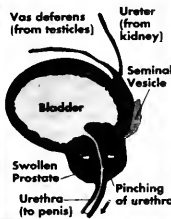
The success rate of TURP is high—about 85 percent—with only 15 percent of men needing a repeat

HOW PROSTATE ENLARGEMENT INHIBITS URINATION

Normal Prostate



Enlarged Prostate



INTERACTIVE VIDEOS GET PATIENTS MORE INVOLVED IN TREATMENT DECISIONS

In 1992, The Foundation for Informed Medical Decision Making, a nonprofit medical education and research foundation based in Hanover, New Hampshire introduced an interactive video program designed to help patients choose a treatment for benign prostate disease. Combining state-of-the-art technology with scientific data, the interactive video offers viewers detailed descriptions of the risks and benefits of treatment options ranging from monitoring symptoms to surgery.

"It brings patients into the equation and makes them equal partners with their doctors in the decision making process," says John E. Wennberg, M.D., a professor of community and family medicine at Dartmouth Medical Center and the creator of the project. "We're beginning to democratize the doctor-patient relationship."

Patients sit in a designated room where they view the video alone or with their spouses. The program begins with a basic overview of benign prostate disease, which includes frank comments from patients who have taken various courses of action. For instance, a man who underwent surgery to relieve painful urinary blockages tells viewers how happy he is with the results. On the flipside, a patient who rejected surgery in favor of "watchful waiting" talks about how satisfied he is with his decision—even though it means he has to get an aisle seat whenever he goes to the movie theater!

After the overview, patients use a touchscreen to tailor information to their individual needs and interests, and fill out questionnaires that are then put into the computer. In order to get a personalized model of their risk factors and treatment options.

Similar interactive programs now exist for patients suffering from low back pain, high blood pressure and early stage breast cancer.

TURP within 8 years. An estimated 400,000 TURPs are performed each year, making TURP the second most common procedure paid for by Medicare, topped only by cataract lens replacement.

But the surgery is not without side effects. After undergoing TURP many men experience *retrograde ejaculation*, in which semen travels back into the bladder rather than out through the penis. This is not medically harmful, but it does render the man infertile and the sensation may take some getting used to. About 4 to 8 percent of patients become permanently impotent.

Drug Therapy: Men with moderate symptoms may be prescribed the new drug Proscar, approved by the Federal Drug Administration (FDA) in June 1992. This drug actually shrinks the prostate by blocking production of the male hormone that stimulates prostate growth. According to researchers, about 70 percent of men who took the drug experienced symptomatic relief. Some of Proscar's drawbacks: It takes effect slowly (it must be taken for one to three months before improvement occurs), it is expensive, it obscures prostate cancer test results, and symptoms generally recur once a man stops taking the drug.

DOES AN ENLARGED PROSTATE INCREASE A MAN'S RISK OF PROSTATE CANCER?

Although researchers are still trying to determine whether BPH increases the risk of prostate cancer, so far there is no evidence of increased risk.

HOW COMMON IS PROSTATE CANCER?

Prostate cancer has become the most common cancer in American men, second only to lung cancer as a cause of cancer deaths. Each year more than 130,000 men are diagnosed with cancer of the prostate; 34,000 will die of it (see cancer chart on p. 31).

Autopsy studies of men in their fifties showed that one third had microscopic prostate cancers. By the time men reach their eighties, 75 percent have some cancerous prostate cells. Still, most cases of prostate cancer are "silent," and grow very slowly. Consequently, it is said that more men die with prostate cancer than from it.

WHO GETS PROSTATE CANCER AND WHY?

The causes of prostate cancer are not known. But studies show that prostate cancer occurs mainly in men over 55; the average age of patients at the time of diagnosis is 70.

The disease is more common in black men than in their white counterparts. In fact, black men in the United States have the highest rate of prostate cancer in the world.

Although doctors cannot explain why one person gets prostate cancer and another does not, one area

HEALTH PAGES

that scientists are currently studying is diet. Some evidence suggests that a diet high in fat (including regular consumption of whole milk and whole milk products like ice cream and certain cheeses) increases the risk of prostate cancer. In fact, in 1991, the FDA proposed that labels on certain low-fat foods be allowed to state that diets high in fat are associated with an increased risk of breast, colon and prostate cancer.

EARLY DETECTION IS THE BEST DEFENSE AGAINST PROSTATE CANCER

Since the causes of prostate cancer are not known, it is not yet possible to know how it can be prevented. Consequently, medical attention has focused on early detection. The earlier the cancer is found, the greater the chances of treatment success. Here is an explanation of the various detection methods currently available.

Digital rectal examination. Both the American Cancer Society and the National Cancer Institute recommend that all men age 40 and older have an annual digital rectal examination. In this exam, the physician inserts a gloved, lubricated finger into the rectum and feels the prostate gland for hard lumpy areas (the procedure usually takes less than one minute). The problem with this method of detection is that tumors may lurk in areas a doctor can't reach. Additionally, many tumors in the early stage of the disease are missed because they are too small to be felt by hand. By the time a tumor can be felt, the cancer may already have spread to other parts of the body, making successful treatment much less likely.

PSA. There is now a simple blood test that measures levels of PSA, prostate-specific antigen, in the blood. High levels of this antigen can indicate BPH or cancer of the prostate. Although studies have shown the PSA test to be the single most accurate detection method, it still misses up to one third of

prostate cancer cases (resulting in false negatives) and signals cancer in up to 40 percent of patients who are cancer free (resulting in false positives).

Ultrasound rectal probe. This test uses sound waves sent out by a probe that is inserted into the rectum to form a computerized picture of the prostate called a sonogram. Ultrasound can detect cancers that may have been missed in the other two exams, but it is not regularly recommended for screening purposes because of its expense and high rate of false positives.

Your best bet for early detection? Having both the PSA test and the rectal exam. One study found that the two tests combined found 30 to 55 percent more prostate cancers than either test alone. Although a doctor cannot diagnose prostate cancer using just these tests, he or she will take their results into account when deciding whether to run further tests.

HOW IS PROSTATE CANCER DIAGNOSED?

If your doctor suspects prostate cancer, he or she will probably refer you to a urologist, a doctor who specializes in diseases of the urinary tract and male reproductive system, for a biopsy. Performing a biopsy is the only way to make a definite diagnosis. How it works: the doctor removes a small amount of prostate tissue, usually

with a needle, and sends it to a lab, where it is examined under a microscope for cancerous cells. Often, a biopsy can be performed in a urologist's office, eliminating the need for a hospital visit.

If prostate cancer is confirmed, the next step is to determine the stage of the disease—whether the cancer has spread beyond the prostate. This is accomplished by performing additional imaging tests, which can include a bone scan, cat scan or magnetic resonance imaging (MRI).

Doctors generally recommend therapy based on the stage of the disease. They also take into account the patient's age and medical history, the probable risks and benefits of treatment, the patient's ability to comply with treatment and the preferences of the patient.

HOSPITAL & LAB PSA PRICES*

| | | | |
|---------------------------|-------|---------------------|-------|
| MILWAUKEE | | Smithkline | \$ 89 |
| Trinity Memorial | \$ 55 | General Medical | 62 |
| St. Joseph's Hospital | 135 | MML Health Services | 98 |
| St. Francis Hospital | 82 | | |
| Northwest General | 54 | GREEN BAY | |
| Milwaukee County Medical | 59 | Bolin Hospital | 77 |
| St. Mary's Hospital | 65 | St. Mary's Hospital | 65 |
| West Allis Memorial | 42 | St. Vincent | 62 |
| Lakeview Hospital | 45 | | |
| Waukesha Memorial | 44 | MADISON | |
| St. Luke's Medical Center | 36 | Mariner-General Med | 62 |
| Elmhurst Memorial | 118 | St. Mary's Hospital | 51 |
| Columbia | 84 | University of WI | 55 |
| Froedtert Hospital | 48 | | |
| St. Mary's-Ozaukee | 92 | | |
| Community Memorial | 52 | | |
| St. Michael's Hospital | 98 | | |

COMMERCIAL LABS

| | | |
|-----------------|-----|---|
| Bayshore | 52 | Medicare's approved payment for PSAs in 1992 was \$31.91 |
| Damon | 103 | Patients without Medicare were charged an average of \$75 |
| Medical Science | 58 | |
| Mutpath | 75 | |
| Rache | 67 | *Prices include blood drawing fee |

HEALTH PAGES

WHAT ARE THE COMMON TREATMENT OPTIONS FOR PROSTATE CANCER THAT HAS NOT SPREAD BEYOND THE PROSTATE?

Early prostate cancer that is confined to the gland itself is more than 90 percent curable with surgical removal of the diseased prostate—*radical prostatectomy*. The surgery used to render most men impotent and many men incontinent, but improvements in surgical techniques over the last few years have reduced the impotency rate to 40 percent. Significant incontinence now only occurs in about 5 percent of cases.

TALKING TO YOUR DOCTOR

Patients generally want to learn all they can about their condition and treatment choices so they can take a more active part in decisions about their medical care. Since treatment for prostate cancer sometimes affects sexual activity and bodily functions, such as urination, it is especially important to weigh the risks and benefits of different treatments.

Although written material is a good start, it cannot take the place of discussion with your doctor. Your physician is best qualified to answer questions about the extent of the cancer, how it can be treated, how successful the treatment is expected to be and how much it is likely to cost. It is helpful to make a list of questions before you see your doctor.

Here are some questions you may want to ask:

- What are my treatment choices?
- What are the expected benefits of each treatment?
- What are the risks and possible side effects of each treatment?
- How will the treatment affect my sex life?
- If I have pain, how will the treatment help me?
- Will I need to change my normal activities? For how long?
- How often will I need to have follow-up exams?

Taking notes can make it easier to remember what the doctor says. Some patients find it also helps to have a family member or friend along to take part in the discussion, to take notes or just to listen.

There's a lot to learn about prostate cancer and its treatment. Don't feel like you need to understand everything the first time you hear it. You will have many opportunities to ask your doctor to explain things that are not clear. Use them.

Radiation therapy is another treatment option. It is not as effective as surgery but it is recommended for older patients who may be poor surgical risks because of their age and/or the coexistence of other complicating illnesses.

WHAT ARE THE TREATMENT OPTIONS WHEN CANCER HAS SPREAD BEYOND THE PROSTATE?

Neither surgery nor radiation are effective once the cancer has spread to the lymph nodes and/or bones. Hormone therapy that counters the stimulation of testosterone or surgical castration is commonly recommended to curb the cancer's growth and prolong life, but there is no known cure.

SHOULD I GET A SECOND OPINION?

Decisions about prostate cancer treatment are complex, and sometimes it's helpful to have the advice of more than one doctor. In fact, if your doctor recommends surgery, many insurance companies require that you obtain a second opinion before they will pay for the full costs incurred. If the second opinion contradicts the first, you may need a third opinion. A short delay in starting treatment will not reduce the chances of treatment success.

Our thanks to David W. McDermott, M.D., F.A.C.S., Anne Arundel Medical Center, Annapolis, MD for reviewing this article.

ESTIMATED CANCER INCIDENCE AND DEATHS - BY SITE, 1992

| INCIDENCE | DEATHS |
|---------------------------------|---------|
| Melanoma of the skin | |
| 17,000 | 4,100 |
| Oral | |
| 20,600 | 5,175 |
| Lung | |
| 102,000 | 93,000 |
| Breast | |
| 1,000 | 300 |
| Pancreas | |
| 13,900 | 12,000 |
| Stomach | |
| 15,000 | 8,000 |
| Colon & rectum | |
| 79,000 | 28,000 |
| Prostate | |
| 132,000 | 34,000 |
| Urinary | |
| 54,700 | 12,700 |
| Leukemia & lymphomas | |
| 49,500 | 25,500 |
| All other | |
| 80,300 | 51,325 |
| All sites | |
| 565,000 | 275,000 |

HEALTH PAGES

| Doctor | Board Certification | Accepts Medicare Assignment ¹ | Primary Hospital Affiliation | Needle Biopsy | Ultrasound Biopsy ² | Trans-urethral Resection | Radical Prostatectomy | Special Interests |
|------------------------------|---------------------|--|------------------------------|---------------|--------------------------------|--------------------------|-----------------------|-----------------------------------|
| Kennedy, Timothy | 1991 | Yes | St. Vincent | \$200 | \$200 | \$2,000 | \$3,500 | Pediatric Urology & Stones |
| Marlett, Myron Max | 1978 | Yes | | 200 | 200 | 2,000 | 3,500 | |
| Schiebler, John Charles | 1974 | Yes | | 200 | 200 | 2,000 | 3,500 | |
| Someland, Arthur Malcolm III | 1985 | Yes | St. Vincent | 200 | 200 | 2,000 | 3500 | Urinary Incontinence |
| Troop Charles W. | 1974 | Yes | Bellin | 149 | 226 | 1,803 | 3,381 | |
| Whitner, Richard | | Yes | | 149 | 226 | 1,803 | 3,381 | |
| Bruskewitz, Reginald C | 1981 | Yes | University | 230 | | 2,300 | 4,410 | |
| Graf, Richard Andrew | 1967 | No | Meriter | 214 | 151 | 2,461 | 4,280 | Prostate, Bladder Tumors & Stones |
| Greenberg, Earl Barry | 1971 | No | St. Mary's | 265 | 196 | 2,232 | 3,786 | |
| Kaplan, Michael Ervin | 1987 | No | Meriter | 214 | 151 | 2,461 | 4,280 | Lithotripsy & Prostate Ultrasound |
| Licklider, Gary Melvin | 1979 | No | St. Mary's | 265 | 196 | 2,232 | 3,786 | |
| Mahler, John Herbert | 1975 | No | Meriter | 214 | 151 | 2,461 | 4,280 | |
| Malek, Gholam H. | 1973 | No | Meriter | 214 | 151 | 2,461 | 4,280 | |
| Messing, Edward M. | 1980 | Yes | University | 230 | | 2,300 | 4,410 | |
| Moon, Timothy David | 1985 | Yes | University | 230 | | 2,300 | 4,410 | |
| Smith, Franklin Lee | 1989 | Yes | University | 230 | | 2,300 | 4,410 | |
| Uehling, David T | 1967 | Yes | University | 230 | | 2,300 | 4,410 | |
| Waters, Rand F | 1970 | No | St. Mary's | 265 | 196 | 2,232 | 3,786 | |
| Wegenke, John D. | 1978 | No | Meriter | 214 | 151 | 2,461 | 4,280 | |
| Andrew, Francis L. | 1969 | No | West Alle Mem. | 143 | 280 | 1,958 | 3,500 | Cancer of Genitourinary System |
| Amesley, William H., Jr. | 1984 | No | | 143 | 280 | 1,958 | 3,500 | |
| Bogun, Frank Philip | 1986 | No | | 191 | 273 | 1,908 | 3,338 | |
| Boerne, Charles W. | 1971 | No | | 200 | | 2,100 | 3,400 | |
| Borras, Richard B. | 1968 | No | | 175 | 92 | 1,742 | 3,132 | |
| Dixon, Christopher | 1992 | No | Froedtert Mem. | 191 | 273 | 1,908 | 3,338 | BPH |
| Fallon, Thomas | 1985 | Yes | Waukegan Mem. | 165 | 95 | 1,834 | N/A | |
| Fine, Stuart W. | 1971 | No | St. Luke's | 273 | 196 | 2,100 | 3,675 | Prostate & Vasectomy Reversal |

HEALTH PAGES

| Doctor | Board Certification | Accepts Medicare Assignment ¹ | Primary Hospital Affiliation | Needle Biopsy | Ultrasound Biopsy ² | Trans-urethral Resection | Radical Prostatectomy | Special Interests |
|------------------------------------|---------------------|--|------------------------------|---------------|--------------------------------|--------------------------|-----------------------|-----------------------------------|
| Fleming, W. Patrick, Jr. | 1990 | Yes | Waukesha Mem. | \$165 | \$95 | \$1,834 | \$2,384 | |
| Harkavy, Raymond | 1963 | Yes | | N/A | N/A | 1,624 | N/A | |
| Holt, Richard C. | 1977 | Yes | Waukesha Mem. | 165 | 95 | 1,834 | N/A | |
| Herrman, Richard A. | 1976 | Yes | | 426* | 426* | 2,160 | N/A | |
| Hodgson, Norman B. | 1961 | No | | 175 | 92 | 1,742 | 3,132 | |
| Jacobsohn, Harold A. | 1976 | Yes | | 121 | | 1,621 | | |
| Kearns, John Westhoben | 1958 | No | Columbia | 150 | N/A | 1,690 | 3,350 | |
| Lawson, Russell K. | 1972 | No | Froedtert Mem. | 191 | 273 | 1,908 | 3,338 | Urologic Oncology |
| Lapor, Herbert | 1987 | No | Froedtert Mem. | 191 | 273 | 1,908 | 3,338 | Prostatectomy & BPH |
| MacGillis, Alexander J. | 1968 | No | | 143 | 280 | 1,958 | 3,500 | |
| Manuel, Emmanuel S. | 1981 | Yes | | 250* | 250* | 1,485 | 2,342 | |
| Otto, Samuel J. | 1983 | No | St. Luke's | 273 | 196 | 2,100 | 3,675 | Prostate Disease & Impotence |
| Pollard, Randle E. | 1961 | Yes | Sinai/Samaritan | | | | | |
| Pope, John Francis | 1990 | No | | 143 | 280 | 1,958 | 3,500 | |
| Rasmussen, Robert James | 1967 | Yes | | 184 | 204 | 2,076 | N/A | |
| Silber, John David | 1958 | Yes | Sinai/Samaritan | 273 | 196 | 2,100 | 3,675 | BPH, Prostate Ultrasound & Biopsy |
| Slocum, Peter | 1990 | No | Columbia | 150 | N/A | 1,690 | 3,350 | |
| Usoy, Barry H. | 1976 | No | | 273 | 196 | 2,100 | 3,675 | |
| Walsh, John Patrick | 1978 | No | St. Joseph's | 175 | 92 | 1,742 | 3,132 | |
| Weisenthal, Charles Leonard | 1964 | Yes | | 327* | 327* | 1,825 | N/A | |
| AVERAGE CHARGE | | | | 199 | | 2,030 | 3,497 | |

¹As of December 1992

²Note: Some of the lower priced ultrasound exams may indicate a separate radiologist charge.

* Needle and ultrasound biopsies are billed at this combined price.

| | Transurethral Resection (TURP) | | Radical Prostatectomy | |
|--|--------------------------------|----------------|-----------------------|----------------|
| | Number of Patients | Average Charge | Number of Patients | Average Charge |
| Bellin Memorial | 89 | \$3,256 | 19 | \$8,279 |
| St. Mary's | 38 | 3,383 | | |
| St. Vincent | 55 | 3,643 | 17 | 8,491 |
| Mariner | 84 | 3,868 | 31 | 9,572 |
| St. Mary's | 84 | 2,579 | 21 | 6,592 |
| University of WI | | | 23 | 13,416 |
| Burlington-Memorial | 20 | 4,469 | | |
| Columbia | 67 | 3,506 | | |
| Elmhurst Memorial-Brookfield | 60 | 3,319 | | |
| Froedtert Memorial | 27 | 6,385 | 27 | 14,978 |
| Lakeview | 24 | 2,965 | | |
| Monona Falls-Community Memorial | 83 | 2,406 | | |
| Milwaukee County Medical | | | | |
| Northwest General | | | | |
| Oconomowoc-Memorial | 18 | 3,501 | | |
| St. Francis | 38 | 3,636 | 11 | 7,504 |
| St. Joseph's | 107 | 3,713 | 17 | 7,928 |
| St. Luke's-Milwaukee | 77 | 3,694 | 24 | 9,338 |
| St. Luke's-Racine | | | | |
| St. Mary's-Milwaukee | 79 | 3,630 | | |
| St. Mary's-Ozaukee | 11 | 3,555 | | |
| St. Michael | 47 | 4,201 | | |
| Sinai Samaritan | 33 | 5,532 | | |
| Trinity | 21 | 3,114 | | |
| Waukesha Memorial | 71 | 3,877 | | |
| West Allis Memorial | 107 | 3,701 | 19 | 8,408 |
| | | 3,724 | | 8,921 |

Source: Market Share Modeling Inc., Lake Mills, WI

Breast Cancer: What You Need to Know

Breast cancer is the most common type of cancer among American women. Experts estimate that a woman in this country stands a one in nine (11 percent) chance of developing breast cancer at some point in her life, assuming she lives to age 85.

In fact, each year in the United States, more than 175,000 women are diagnosed with breast cancer—that's equivalent to a woman learning she has breast cancer every three minutes. An estimated 46,000 women will die of the disease in 1992 alone, according to the American Cancer Society (ACS).

WHO'S AT RISK?

Medical science has yet to fully understand what factors predispose a woman to breast cancer. But as a woman ages, her risk increases. Other possible risk factors include:

- Having a mother or sister who has had breast cancer, especially if the cancer occurred before menopause
- Early menstruation (before age 12)
- Late menopause (55 or older)
- Never being pregnant or a first pregnancy after age 30

It is important to note that all of these factors combined account for only 25 percent of all breast cancers—a full 75 percent of women who develop breast cancer have none of these risk factors.

WHAT IS THE BEST DEFENSE AGAINST BREAST CANCER?

EARLY DETECTION!! To ensure the widest range of treatment options, it is important to detect breast cancer

as early as possible. With prompt treatment, the outlook for cure is good. According to the National Cancer Institute (NCI), the five-year survival rate for women whose tumors haven't spread beyond the breast is 90 percent. When the cancer has spread to nearby lymph nodes under the arm, the rate decreases to 71 percent, dropping drastically to 18 percent once the cancer has spread to the liver, lungs or brain.

BREAST CANCER DETECTION PLAN: AMERICAN CANCER SOCIETY GUIDELINES

[1] MAMMOGRAPHY

Beginning at age 40, a woman should have a mammogram every 1 to 2 years, annually after age 50.

What is a mammogram? A mammogram is an x-ray of the breast. It can reveal tumors too small to be felt by hand and can show other changes in the breast that may suggest cancer. When high-quality equipment is used and the x-rays are read by well-trained radiologists, 85 to 90 percent of cancers are detectable. Of the 10 to 15 percent of cases that don't show up on mammograms, most occur in younger women with dense, fibrous breast tissue in which lesions are difficult to spot.

How a mammogram works: The breast is placed between two plates and some pressure is applied to ensure a clear picture. Women may experience varying degrees of discomfort during breast compression. Usually, two x-rays are taken of each breast, one from the top and one from the side. Although some women are concerned about the risk of

Breast Cancer Risk by Age

| Age | Risk |
|-----------|------------|
| by age 30 | 1 in 2,525 |
| by age 40 | 1 in 217 |
| by age 50 | 1 in 50 |
| by age 60 | 1 in 24 |
| by age 70 | 1 in 14 |
| by age 80 | 1 in 10 |
| by age 85 | 1 in 9 |

HEALTH PAGES

cancer posed by radiation exposure during mammography, the actual risk is very small.

[2] PHYSICAL BREAST EXAM

All women should have breast examinations as part of their routine checkups. Women 40 and older should have them annually.

Periodic breast examination by a health professional is an important step in early detection. During the exam, the doctor feels the breast and underarm with his or her fingers, checking for lumps. This is called palpation.

[3] BREAST SELF-EXAMINATION (BSE)

Beginning at age 25, women should do monthly breast self-examinations.

Women's breasts come in many sizes and shapes. Age, the monthly menstrual cycle, pregnancy, menopause and taking birth control pills or other hormones can all result in breast changes. It is important to learn what is normal for you. This can be accomplished with regular BSE. The exam is easy to do, and as the name states, you do it yourself—making it a good way to take charge of your health.

BSE should be done once a month after menses. (See page 39 for step-by-step instructions on how to do BSE.) Being familiar with the usual appearance and feel of your breasts on a monthly basis will make it easier to notice any changes from month to month. If you discover anything unusual, such as a lump, discharge from the nipples, or dimpling or puckering of the skin, see your doctor at once. Although many women have irregular or "lumpy" breasts, and many doctors believe that nearly all women will have some benign breast changes (changes in a woman's breasts that are not cancerous) after age 30, any change is best diagnosed by your doctor.

HOW IS BREAST CANCER DIAGNOSED?

A biopsy is the only surefire way to know whether a breast lump or suspicious area seen on a mammogram is, in fact, cancer. In a biopsy, the doctor surgically removes all or part of the lump and sends it to a laboratory for analysis.

The good news: Four out of five breast lumps are not cancerous. Often the lump is a fluid-filled cyst, which can most likely be drained by fine needle aspiration. If the lump is a benign tumor, it often can be surgically removed with no further problems. Some lumps may just need to be monitored regularly for changes.

If the biopsy shows that the lump is cancer, other laboratory tests may be performed to determine whether the cancer has spread from the breast to other parts of the body.

A CONSUMER'S GUIDE TO MAMMOGRAPHY

Two important issues to consider when choosing a mammography facility are quality and cost.

One sign of a facility's quality: American College of Radiology (ACR) accreditation. Facilities accredited by ACR have had their equipment, personnel and procedures evaluated and approved by the college. Their doctors and other staff members are specially trained to perform and read breast x-rays. And their equipment and procedures are designed to provide high-quality mammograms with the lowest possible amount of radiation exposure.

However, since accreditation is voluntary, it is possible for a facility to be of high quality and not be accredited by ACR. If you are considering a facility that is not ACR accredited, you should ask the following questions to help you evaluate whether the facility is a good one.

1. *Is the x-ray equipment specifically designed for mammography?* These are called dedicated mammography machines and provide higher quality breast x-rays than a machine that also takes x-rays of the bones and other parts of the body.

2. *Are your x-ray technologist and radiologist trained in mammography?* Technologists perform the exam and must be trained to position the breast correctly to get a good picture. Radiologists are medical doctors who interpret the results of the mammogram; they should have taken special courses in mammography and be board certified (which indicates that they have been properly trained and have passed the necessary oral and written tests).

3. *Does the radiologist read at least 10 mammograms a week?* Radiologists who read fewer than that number may be less skilled at identifying the signs of a cancerous tumor.

4. *Is the mammography machine calibrated (tested for correct measurements and radiation doses) at least once a year?*

Feel free to call and ask these questions before you make an appointment. A qualified facility should be able to answer your questions easily. If the facility's representative is reluctant to answer your questions, look for another facility.

DOLLARS AND SENSE

The cost of a mammogram ranges from \$49 to \$189. In the last several years, many insurance companies have begun to pay for routine screening mammograms as well as for diagnostic mammograms to evaluate a specific lump. Medicare reimburses up to \$55 for one mammogram every other year.

When comparing mammogram prices, keep in mind that a higher priced mammogram can be easily justified if a facility provides additional services such as a physical breast exam and instruction in breast self-examination.

| Center | ACR Accreditation Status | Breast Exam Given By | Self-Exam Instruction Given By | Mammography Price | Ultrasound Price | Accepts Medicare Assignment | Results Given To Dr./Patient | Walk-ins Welcome | Evening & Weekend Hours | Accepts Self Referral |
|---------------------------------|--------------------------|----------------------|--------------------------------|-------------------|------------------|-----------------------------|------------------------------|------------------|-------------------------|-----------------------|
| GREEN BAY | | | | | | | | | | |
| Beaumont Clinic | Approved | Dr | Dr | \$107 | \$244 | No | Dr | No | No | No |
| Bellin Memorial Hospital | Pending | None | None | 97 | 132 | \$ | Dr | No | Yes | No |
| St. Mary's Hospital | Pending | None | Video | 99 | 160 | \$ | Dr | Yes | No | No |
| St. Vincent Hospital | Approved | None | Video | 99 | 160 | \$ | Dr | No | No | No |
| MADISON | | | | | | | | | | |
| Dean Medical Center | No | None | Nurse/Video | 150 | 123 | No | Both | No | Yes | Yes |
| Meriter Hospital | Approved | Nurse | Nurse | 178 | 282 | Yes | Both | No | No | Yes |
| St Mary's Hospital | No | None | None | 189 | 192 | \$ | Dr | No | No | No |
| University of Wisconsin | Approved | Nurse | Nurse/Video | 50/140* | 247 | Yes | Both | No | No | Yes |
| MILWAUKEE | | | | | | | | | | |
| Breast Diagnostic Clinic | Approved | Dr/Tech | Tech | 120 | 63 | Yes | Both | No | Evng | Yes |
| Memorial Hospital of Burlington | Pending | None | None | 124 | 272 | Yes | Both | No | Evng | Yes |
| Coleman Sorel Center | Approved | | | 120 | 153 | Yes | | | | |
| Columbus Hospital | Approved | Tech | Tech | 150 | 252 | \$ | | Yes | Yes | Yes |
| Elmbrook Internal Medicine | Approved | | | 122 | N/A | | | | | |
| Elmbrook Memorial Hospital | Approved | Tech | Tech/Video | 138 | 222 | \$ | Dr | No | Yes | No |
| Fine-Landis Clinic | Approved | Dr | Video | 110 | 121 | Yes | Both | No | Wkend | No |
| Kurten Medical Group | Approved | Dr | Dr/Video | 85 | 171 | Yes | Dr | No | Wkend | No |
| Menomonee Falls, Comm Mem | Pending | Tech | Video | 55/137* | 182 | Yes | Both | No | Evng | Yes |
| Milw County Medical Complex | Approved | Tech | Tech/Video | 121 | 170 | Yes | Dr | No | No | Yes |
| Milwaukee Medical Clinic | Approved | Dr | Video | 145 | 108 | No | Dr | No | Yes | No |
| Moreland Medical Center | Approved | | | 100 | 188 | No | | | | |
| Newtowne Medical Group | Approved | Tech | Tech/Video | 120 | 153 | Yes | Dr | Yes | No | Yes |
| Oconomowoc Memorial | Approved | Nurse | Nurse/Video | 65/145* | 251 | \$ | Both | No | No | Yes |
| Racine Medical Clinic | Approved | | | 74 | 168 | Yes | | | | |
| St Francis Hospital | Approved | Tech | None | 159 | 174 | \$ | Dr | No | Evng | No |
| St. Luke's Medical Center-Milw | Approved | Dr/Tech | Video/Tech | 158 | 215 | Yes | Dr | No | Evng | Yes |
| St. Luke's - Racine | Approved | Tech | Video | 83 | 162 | Yes | Both | No | Wkend | Yes |
| St. Mary's Hospital - Milw | Approved | Nurses | Nurse/Video | 70/151* | 278 | Yes | Both | No | Yes | Yes |
| St. Mary's Med Center - Racine | Approved | | | 94 | 159 | Yes | | | | |
| St. Michael Hospital | Approved | Nurse | Video | 112 | 171 | \$ | Dr | No | Yes | Yes |
| Shed Samaritan Medical Center | Approved | Tech | Video | 49/169* | 220 | Yes | Both | Yes | No | Yes |
| Trinity Memorial Hospital | Pending | Nurse | Nurse/Video | 75/161* | 225 | Yes | Both | No | No | Yes |
| Waukesha Memorial Hospital | Approved | None | Video | 108 | 232 | \$ | Dr | No | Yes | Yes |
| West Allis Memorial Hospital | Approved | Tech | Tech | 184 | 246 | Yes | Dr | Yes | Yes | |

* Some charges may apply. Prices are for patients without insurance and do not include taxes and fees.

¹ As of December 1992

HEALTH PAGES

WHAT ARE THE TREATMENT OPTIONS FOR BREAST CANCER?

Treatment for breast cancer depends on the type of cancer and how far it has spread, as well as on a woman's age, menopausal status and general health. The doctor will develop a treatment plan to fit a woman's individual needs.

Before starting treatment, a woman might want a second doctor to review her diagnosis and treatment plan. A short delay in beginning treatment will not reduce the chances of treatment success. There are a number of ways to find a doctor for a second opinion:

- Call the local medical society or nearby hospitals. Refer to page 40 for a listing of local oncologists and breast cancer surgeons.

- Ask friends for recommendations.

Methods of Treatment

The treatment options for breast cancer are surgery, radiation therapy, chemotherapy and hormone therapy. The doctor may recommend just one method or a combination, depending on the patient's needs. In some cases, the patient may be referred to other doctors for different therapies.

SURGERY: This is the most common treatment for breast cancer. There are several different types of surgery:

- **Radical mastectomy** removes the breast, chest muscles, all of the lymph nodes under the arm and some additional fat and skin. This operation was the standard treatment for many years. It is still used on occasion, but for most patients, less extensive surgery has been shown to be just as effective.

- **Modified radical mastectomy** removes the breast, the lymph nodes under the arm and the lining over the chest muscles (leaving the muscles intact). This is the most common surgical treatment for breast cancer.

- **Lumpectomy** removes just the breast lump and usually the lymph nodes under the arm. About two to three weeks after surgery, patients begin radiation therapy, which generally consists of a five-day-a-week regimen for six weeks. Lumpectomy is a common treatment choice for women who are diagnosed with early stage breast cancer. Research has shown that when combined with radiation, lumpectomy is as effective as mastectomy in treating early stage breast cancer.

ADJUVANT THERAPY: A doctor may advise a woman with early stage breast cancer to supplement surgery and/or radiation with chemotherapy or hormone therapy. Called adjuvant therapy, this additional regimen can help prevent cancer from recurring by killing cancer cells that may still be lingering in the body undetected.

Chemotherapy uses drugs to kill cancer cells. These drugs may be taken orally or injected into a muscle or vein. Chemotherapy is administered in cycles—a treatment period followed by a rest period, then another series of treatments, and so on. Although it depends upon the type of drugs used, chemotherapy generally does not require a hospital stay.

Hormone therapy keeps cancer cells from getting the hormones they need to grow. Drugs may be administered to alter the way the hormones work or surgery may be performed to remove organs (such as the ovaries) that manufacture the offending hormones.

TALKING TO YOUR DOCTOR

Concerns about what the future holds—as well as worries about tests, treatments, hospitalization and medical bills—are common. Talking with doctors and nurses may help to calm those fears and ease confusion. Asking questions about her condition and treatment choices can also help a woman take an active part in decisions about her medical care. Here are some examples of questions to ask the doctor:

- What are my treatment choices?
- What are the benefits of each treatment?
- What are the risks and side effects of each treatment?
- How will I look after treatment?
- Will I need to change my normal activities? For how long?
- Can I keep working during treatment?
- How often will I need to have checkups?
- What's the cure rate/prognosis?

Patients often find it helpful to keep a written list of questions to ask the doctor. Taking notes during visits can help patients remember what was said. Some people find it beneficial to have friends or family members accompany them on these visits. Never be afraid to ask the doctor to explain something that is not clear.

HEALTH PAGES

RESOURCES FOR BREAST CANCER PATIENTS AND THEIR FAMILIES

General information about breast cancer is widely available. Some helpful resources are listed below. You may also want to see what your local library has to offer and contact support groups in your community.

Health professionals and patients alike have learned the value of mutual support among cancer patients. When someone who has a serious illness feels frightened or depressed, it often helps to talk about those feelings with a person who has been through a similar experience. A patient's family members and loved ones can also benefit from this type of support.

• **CANCER INFORMATION SERVICE** (1-800-4-CANCER) is a National Cancer Institute nationwide telephone service set up to answer questions from the public. Many informative booklets on all aspects of breast cancer are available free of charge.

• **AMERICAN CANCER SOCIETY (ACS)** is a nonprofit organization that offers a variety of services. The group's *Reach to Recovery* program is specially designed for breast cancer patients. Trained volunteers, all of whom have had breast cancer themselves, visit patients and provide emotional support before and after treatment. Contact your local chapter for more information.

Green Bay: 1600 Shawano Avenue
414-496-9250
Madison: 1 Paint Place 608-833-4555
Milwaukee: 11401 Watertown Plk Rd.
1-800-227-2345

• **ENCORE**, sponsored by the YWCA, is a national breast cancer surgery recovery program that incorporates exercise and group discussions. With her doctor's permission, a woman may sign up for the program beginning the third week after surgery. Contact your local chapter for more information.

Green Bay: 414-432-5581
Madison: 608-257-1436
Waukesha: 414-547-1872

• **NATIONAL ALLIANCE OF BREAST CANCER ORGANIZATIONS (NABCO)** provides breast cancer patients with information to help them make decisions about treatment. For information write to NABCO at 1180 Avenue of the Americas, New York, N.Y. 10036 or call 212-719-0154.

• **Y-ME** (800-221-2141) is a toll-free hotline staffed by women with breast cancer. In addition to providing information, Y-ME can direct callers who want to volunteer time or money to a breast cancer organization.

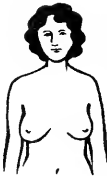
BREAST SELF-EXAMINATION

Breast self-examination should be done once a month so you become familiar with the usual appearance and feel of your breasts. Familiarity makes it easier to notice any changes in the breast from one month to another. Early discovery of a change from what is "normal" is the main idea behind BSE. The outlook is much better if you detect cancer in an early stage.

If you menstruate, the best time to do BSE is 2 or 3 days after your period ends, when your breasts are least likely to be tender or swollen. If you no longer menstruate, pick a day, such as the first day of the month, to remind yourself it is time to do BSE.

Here is one way to do BSE:

1 Stand before a mirror. Inspect both breasts for anything unusual such as any discharge from the nipples or puckering, dimpling, or scaling of the skin.



The next two steps are designed to emphasize any change in the shape or contour of your breasts. As you do them, you should be able to feel your chest muscles tighten.

2 Watching closely in the mirror, clasp your hands behind your head and press your hands forward.



3 Next, press your hands firmly on your hips and bow slightly toward your mirror as you pull your shoulders and elbows forward.



Some women do the next part of the exam in the shower because fingers glide over soapy skin, making it easy to concentrate on the texture underneath.



4 Raise your left arm. Use three or four fingers of your right hand to explore your left breast firmly, carefully and thoroughly.



Beginning at the outer edge, press the flat part of your fingers in small circles, moving the circles slowly around the breast. Gradually work toward the nipple. Be sure to cover the entire breast. Pay special attention to the area between the breast and the underarm, including the underarm itself. Feel for any unusual lump or mass under the skin.

5 Gently squeeze the nipple and look for a discharge. (If you have any discharge during the month—whether or not it is during BSE—see your doctor.) Repeat steps 4 and 5 on your right breast.



6 Steps 4 and 5 should be repeated lying down. Lie flat on your back with your left arm over your head and a pillow or folded towel under your left shoulder. This position flattens the breast and makes it easier to examine. Use the same circular motion described earlier. Repeat the exam on your right breast.

HEALTH PAGES

| Doctor | Board Certification | Accepts Medicare ¹ Assignment | New Patient Office Visit | Established Patient Office Visit | Hospital Affiliation | Special Interests |
|------------------------|---------------------|--|--------------------------|----------------------------------|----------------------|---|
| Bayer, Gerald | 1979 | No | | \$45 | St. Vincent | |
| Blank, Jules | 1985 | No | \$135 | 95 | | Pain Control & Adult Hematology/Oncology |
| Kock, Paul | 1977 | No | | 45 | St. Vincent | |
| McGovern, James | 1983 | No | | 45 | St. Vincent | |
| Carbone, Paul | 1979 | Yes | 138 | 101 | Univ of WI | Breast Cancer, Clinical Trials & Prevention |
| Diggs, Charles | 1977 | No | 135 | 97 | St. Mary's | |
| Ersikler, William | 1981 | Yes | 138 | 101 | Univ of WI | Aging & Cancer |
| Kahler, Peter | 1985 | No | 141 | 107 | Meriter | |
| Longe, Walter | 1987 | Yes | 138 | 101 | Univ of WI | Bone Marrow Transplant |
| Prosdorger, Edward | 1981 | No | 135 | 97 | St. Mary's | |
| Robins, Henry | 1981 | Yes | 138 | 101 | Univ of WI | Breast Cancer, Systemic Hyperthermia & Lymphoma |
| Anderson, Tom | 1977 | No | 159 | 115 | | |
| Bonzer, Charles | 1985 | No | 100 | 53 | | |
| Burden, Ernest | 1975 | Yes | 159 | 115 | | |
| Chitambar, Christopher | 1983 | No | 159 | 115 | Milw County | Leukemia, Lymphoma |
| Dwyer, John | 1983 | No | | 73 | St. Luke's-Milw | |
| Dubeer, Howard | 1977 | Yes | 160 | 50 | | |
| Golner, Nicholas | 1975 | Yes | 160 | 50 | Columbia | Breast Cancer & Hematologic Malignancies |
| Horwitz, Lawrence | | Yes | | 54 | Sinai Samaritan | |
| Kalish, Gerald | 1973 | No | 155 | 85 | Trinity | |
| Oesterling, Kurt | 1983 | Yes | 160 | 50 | | |
| Roth, Paul | 1979 | No | 159 | 115 | | |
| Schwartz, Michael | | Yes | 105 | 69 | Columbia | |

¹ As of December 1992

HEALTH PAGES

| Doctor | Board Certification | Accepts Medicare Assignment ¹ | New Patient Office Visit | Established Patient Office Visit | Hospital Affiliation | Special Interests |
|----------------------|---------------------|--|--------------------------|----------------------------------|----------------------|--|
| Singson, Juanita | | No | \$155 | \$85 | Sinai Samaritan | |
| Taylor, Robert | 1983 | No | 151 | 92 | St. Luke's-Milw | Breast Cancer & Bone Marrow Transplant |
| Vukelich, Majorie | 1987 | Yes | 160 | 50 | | |
| Weissman, David | 1985 | No | 159 | 115 | | |
| AVERAGE PRICE | | | 145 | 82 | | |
| | | | | | | |
| Cooley, Gregory | | No | 178 | 69 | | |
| Schlise, Sally | | No | 178 | 69 | | |
| Steeves, Richard | 1980 | Yes | | | Univ of WI | |
| Stitt, Judith | | Yes | | | Univ of WI | |
| Bruckman, James | 1977 | No | 178 | 69 | | |
| Richards, Marcia | 1974 | No | 178 | 69 | | |

| Doctor | Board Certification | Accepts Medicare Assignment ¹ | Breast Biopsy | Lump-ectomy | Radical Mastectomy | Hospital Affiliation | Special Interests |
|-------------------|---------------------|--|---------------|-------------|--------------------|----------------------|--|
| GREEN LAY | | | | | | | |
| Anderas, Per | 1987 | Yes | \$424 | \$1,355 | \$1,750 | | Vascular & Laparoscopic Surgery, Endoscopy |
| Bernacki, Michael | 1988 | No | 500 | 1,700 | 1,900 | St. Vincent's | Laparoscopic & Endoscopic Surgery |
| Geocaris, Thomas | 1975 | Yes | 424 | 1,355 | 1,750 | Bellin Mem. | Laparoscopic Surgery |
| Mankie, David | 1980 & 1990 | No | 530 | 1,180 | 1,920 | St. Mary's | Vascular Surgery |
| Reckard, Paul | | No | 530 | 1,180 | 1,920 | St. Mary's | Pediatric and Thoracic Surgery |
| MADISON | | | | | | | |
| Bernhardt, Louis | 1969 | No | 615 | 2,153 | 2,328 | St. Mary's | |
| Decock, David | 1978 | No | 615 | 2,153 | 2,328 | St. Mary's | |
| Mockman, Sanford | 1964 | No | 714 | 2,238 | 2,249 | Meriter | |
| Vega, Roland | 1985 | No | 714 | 2,238 | 2,249 | Meriter | |

¹ As of December 1992

HEALTH PAGES

| Doctor | Board Certification | Accepts Medicare Assignment? | Breast Biopsy | Lump-ectomy | Radical Mastectomy | Hospital Affiliation | Special Interests |
|--------------------|---------------------|------------------------------|---------------|-------------|--------------------|----------------------|--|
| Wenger, Ronald | 1978 | No | \$615 | \$2,153 | \$2,328 | St. Mary's | |
| Welberg, William | 1962 | Yes | 650 | 2,100 | 2,300 | Univ of WI | Breast Disease |
| Altman, David | 1969 | Yes | 400 | 1,600 | 1,600 | Sinai Samaritan | Breast, Gallbladder, Stomach, Colon, Thyroid |
| Battista, Joseph | 1989 | Yes | | | | St. Joseph's | |
| Bowman, John | 1972 | Yes | 463 | 1,574 | 1,759 | West Allis | Endocrine, Vascular Surgery |
| Davies, William | 1972 | No | 426 | 1,650 | 1,700 | Waukesha Mem | |
| Ekbo, Gregory | 1982 & 1990 | No | 400 | 1,600 | 1,600 | West Allis | |
| Farrell, David | 1985 | No | 500 | 1,625 | 2,000 | St. Luke's-Milw | Breast Cancer, Colon Cancer |
| Flynn, George | 1962 | Yes | | | | | |
| Fox, Paul | 1974 | No | 426 | 1,650 | 1,700 | Waukesha | |
| Grieshop, Joseph | 1972 | Yes | 463 | 1,574 | 1,759 | West Allis | Vascular Surgery |
| Hardacre II, Jerry | 1991 | Yes | 493 | 1,818 | 2,122 | St. Mary's - Racine | |
| Jan, Mascher | 1974 | Yes | 440 | 1,900 | 1,617 | St. Francis | |
| Kelley, William | 1974 | Yes | 440 | 1,760 | 1,760 | St. Joseph's-Milw | Colon & Rectal Surgery |
| Kispart, John | | Yes | 463 | 1,574 | 1,759 | West Allis | Vascular Surgery |
| Malinowski, Rodney | 1983 & 1991 | Yes | 533 | 1,843 | 2,084 | St. Mary's-Racine | Hand Surgery |
| Mikkelsen, Wendy | 1988 | Yes | 440 | 1,600 | 1,760 | St. Luke's | Breast Disease |
| Mittel, Ram | 1978 & 1987 | No | 458 | 1,590 | 1,870 | Trinity Mem | General & Vascular Surgery |
| Pavlovitz, Gwenn | 1987 | No | | | | | |
| Poquet, Archibald | 1987 | No | 426 | 1,650 | 1,700 | Waukesha Mem | |
| Sartor, Marvin | 1956 | Yes | 450 | 880 | 1,760 | Sinai Samaritan | Laser & Laparoscopic Surgery |
| Schmidt, Robert | 1973 | No | | | | | |
| Schmidt, David | 1988 | No | 335 | 1,650 | 1,700 | Waukesha Mem | |
| Slaight, Douglas | 1976 & 1985 | No | 504 | 1,725 | 2,016 | Trinity Mem | Breast Disease, Breast Cancer |
| Stobbe, Karel | 1966 & 1981 | Yes | 450 | | 1,700 | St. Francis | |
| Tiffany II, Joseph | 1973 | Yes | 460 | 1,380 | 1,840 | St. Mary's-Racine | Breast Carcinoma, Colon Carcinoma, Trauma |
| Tinn, Mark | | No | 606 | 1,568 | 2,398 | Monomonaie Falls | Minimally Invasive Surgery |
| Vincent, Dennis | 1989 | No | 400 | 1,600 | 1,600 | West Allis | Vascular & Laparoscopic Surgery, Angioplasty |
| Wilson, Donald | 1977 & 1986 | Yes | 438 | 1,553 | 1,752 | Columbia | Laser & Laparoscopic Surgery |
| Woods, James | 1976 & 1986 | No | 400 | 1,600 | 1,600 | St. Joseph's | Colonoscopy, Endoscopy, Vascular Surgery |

¹ As of December 1992

HEALTH PAGES

| Hospital | MASTECTOMY | | LUMPECTOMY | | OPEN BIOPSY OF BREAST (Outpatient) | |
|------------------------------|-----------------------|-------------------|-----------------------|-------------------|---------------------------------------|-------------------|
| | Number of Patients | Average Charge | Number of Patients | Average Charge | Number of Patients | Average Charge |
| GREEN BAY | | | | | | |
| Bellin Memorial | 27 | \$3,552 | | | 110 | \$1,401 |
| St. Mary's | 27 | 3,814 | | | 31 | 1,770 |
| St. Vincent | 39 | 3,729 | | | 55 | 1,682 |
| MADISON | | | | | | |
| Meritor | 33 | 4,011 | 12 | \$3,486 | 212 | 1,523 |
| St. Mary's | 45 | 3,213 | 22 | 2,229 | 200 | 1,260 |
| University of WI | 63 | 4,852 | 30 | 3,970 | | |
| MILWAUKEE | | | | | | |
| Burlington-Memorial | 12 | 4,845 | | | 51 | 1,691 |
| Columbia | 33 | 4,880 | 25 | 3,594 | 183 | 1,045 |
| Elmbrook Memorial-Brookfield | 18 | 3,104 | | | 72 | 819 |
| Monomonia Falls Community | 11 | 3,529 | 13 | 3,616 | 90 | 1,421 |
| Milwaukee County Medical | | | | | 55 | 1,807 |
| Northwest General | | | | | 13 | 1,725 |
| Oconomowoc Memorial | 15 | 4,924 | | | | |
| St. Francis | 37 | 4,387 | | | 80 | 1,145 |
| St. Joseph's | 49 | 4,141 | 21 | 3,594 | 424 | 1,102 |
| St. Luke's - Milwaukee | 39 | 4,338 | 15 | 3,881 | 340 | 953 |
| St. Luke's - Racine | | | | | 12 | 1,058 |
| St. Mary's - Milwaukee | 18 | 4,145 | | | 197 | 1,589 |
| St. Mary's - Ozaukee | | | | | 12 | 1,070 |
| St. Michael | 22 | 4,698 | | | 20 | 1,805 |
| Sinai Samaritan | 26 | 7,684 | 14 | 6,487 | 30 | 2,954 |
| Trinity | | | | | 83 | 986 |
| Waukesha Memorial | 59 | 3,905 | 14 | 3,361 | 382 | 1,443 |
| West Allis Memorial | 36 | 3,870 | 13 | 3,236 | 276 | 1,335 |
| AVERAGE CHARGE | | | | | | |

*Minimum of ten patients necessary for inclusion in chart

Source: Mordecai Stone Modeling, Inc., Lake Mills, WI

Medicare and Medigap Made Easy

New rules are now in effect nationwide that will make it easier for older consumers to comparison-shop for insurance policies to supplement their Medicare benefits.

Medicare, the government's healthcare program for older Americans, is divided into two parts:

Medicare Part A – which covers hospital costs – is available free to anyone 65 or older who qualifies for Social Security benefits. Eligible individuals should contact the Social Security Administration before their 65th birthday to ensure coverage.

Medicare Part B – which covers doctor's fees, laboratory tests, x-rays and other outpatient services – charges a premium of \$36.60 a month, which can be deducted from an individual's monthly Social Security check.

But since Medicare does not cover all health care costs, many people choose to buy private supplemental insurance, known as Medigap policies, to pay for deductibles, co-payments and other expenses.

The good news: As of July 30, 1992, insurers in virtually all states are required to offer standardized Medigap policies, making it easier for consumers to compare the coverage and premiums of different insurance companies when shopping for a policy. (Wisconsin has received an exemption from the federal standardization regulations on Medigap, since the state's regulations are equal to, or more stringent than, the national regulations.) But you still need to ask the right questions in order to make careful, informed coverage choices. Here are some questions you should be asking along with tips to make Medigap shopping easier.

WHAT TYPES OF MEDIGAP POLICIES ARE AVAILABLE UNDER THE NEW RULES?

Every new Medigap policy must have a core package of benefits that will pay the co-insurance portion of Medicare Part A hospital benefits

for the first 150 days in the hospital, and offer 100 percent coverage of up to 365 additional days over the course of the insured's life. Without supplemental insurance, Medicare patients with prolonged hospital stays are responsible for \$163 per day for the 61st through the 90th day in the hospital, \$326 a day for days 91 through 150 and full costs after that. The basic Medigap policy also pays the 20 percent of doctors' bills not covered by Medicare, as well as the cost of the first three pints of blood drawn for tests per year.

MEDIGAP COVERAGE OPTIONS

Here are the 10 different types of plans, labeled A to J, that are available under the new standards. The basic package is included in all.

| | A | B | C | D | E | F | G | H | I | J |
|-----------------------|---|---|---|---|-------|-----|------|------|-------|-------|
| Basic | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Skilled Nursing Home | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hospital Deductible | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Doctor Deductible | | ✓ | | | | | | | | ✓ |
| Excess Doctor Charges | | | | | | 80% | 100% | 100% | 100% | 100% |
| Foreign Travel | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| At-Home Recovery | | | | ✓ | | ✓ | | | ✓ | ✓ |
| Prescription Drugs | | | | | BASIC | | | | BASIC | EXT.* |
| Preventive Screening | | | | | | | ✓ | | | ✓ |

NOTE: The basic package includes payment of the patient's 20% share of coverage for doctors' services, \$163-per-day contribution to hospital bills for the 61st through 90th day, the patient's contribution for blood tests and some coverage for hospital stays beyond 90 days.

* Extended

HEALTH PAGES

More elaborate and expensive Medigap insurance policies include the basic benefits plus varying degrees of added coverage. Prices vary by state, insurance company and the age of the insured.

WHAT ADDED BENEFITS ARE AVAILABLE UNDER THE BROADER MEDIGAP POLICIES?

Additional benefits include coverage of a patient's hospital bill (currently \$676 per illness episode), the \$100 annual deductible on doctors' bills, prescription drugs and preventive care.

Neither Medicare nor Medigap covers nursing home expenses. Seniors looking for that kind of protection must purchase a separate long-term care insurance policy.

WHO SHOULD BUY MEDIGAP INSURANCE?

Anyone who needs and can afford private insurance to meet health care costs that Medicare doesn't cover and who is not covered by a former employer's health-insurance plan should consider Medigap.

People with serious health problems who are approaching 65 should definitely take advantage of the open enrollment period for Medigap policies. During this period, which ends six months after an individual first enrolls in Medicare part B, either at age 65 or later at retirement, insurance companies cannot deny coverage to a new policyholder based on his or her medical history. However, the insurer is permitted to require a six-month waiting period before covering medical costs related to a pre-existing condition.

| | Health History | Waiting Period | Years Selling Medigap | BASIC POLICY (By Age) | | | | | ADDITIONAL PREMIUM OPTIONS | | | | |
|---|----------------|----------------|-----------------------|--|-------|-------|-------|-------|--------------------------------------|-------------|---------------|----------------|----------------|
| | | | | 65 | 70 | 75 | 80 | 80+ | Part A Deduct | Home Health | Part B Deduct | Foreign Travel | Excess Charges |
| Amer. Family Life Assur. | Yes | 60 Days | 5 | \$629 | \$724 | \$800 | \$908 | \$908 | \$216* | \$47* | \$84* | \$24* | \$148* |
| American Republic | Yes | None | 12 | 354 | 434 | 489 | 541 | 583 | 152* | 80 | 92 | 5 | 190* |
| Banker's Life | Yes** | 60 Days | 26 | 439 | 536 | 665 | 845 | 845 | 138* | 61* | 75* | 18* | 191* |
| Blue Cross | Limited | 180 Days† | 26 | 420 | 564 | 636 | 720 | 720 | 180 | 24 | 72 | 60 | 240 |
| Continental General+ | Yes | 6 Months | 7 | 458 | 498 | 533 | 563 | 588 | 234* | 40* | 90 | 12* | 200* |
| Medico Life Insurance | Yes** | None | 10 | 527 | 588 | 640 | 693 | 693 | 233* | 28* | 83* | 38* | 226* |
| North Amer. Insurance | Yes | 90 Days† | 3 | 512 | 569 | 598 | 622 | 647 | 226* | 35 | 90 | 20 | 254* |
| Pekin | Yes | — | 14 | 631 | 730 | 836 | 934 | 1,139 | 207 | 20 | 207 | 23 | 207 |
| Mutual of Omaha+ | No | 6 Months | 26 | 417\$ | 519\$ | 603\$ | 696\$ | 696\$ | 278 | 18 | 92 | 18 | 155* |
| Physicians Mutual Ins. Co. | Limited | None | — | 384 | 413 | 413 | 461 | 461 | 244* | 61* | 88 | 11 | 330 |
| + Has a prescription drug policy option | | | | ** Excluding open enrollment | | | | | § Plus \$11.97 for Diabetes Coverage | | | | |
| * Age 65 | | | | † Waived first 6 months enrolling Part B | | | | | | | | | |

HEALTH PAGES

SHOULD I SWITCH TO ONE OF THE NEW POLICIES IF I ALREADY HAVE MEDIGAP INSURANCE?

If you are satisfied with your current policy, there is no need to switch. Many existing Medigap policies are quite good and may cover items, such as the cost of a private hospital room, that newer policies don't.

If you decide to shop for a new policy, consider what type of coverage you need and can afford, keeping in mind that annual premiums will probably continue to rise. When comparing the prices charged by different companies, look at the premium for your age now as well as what it would be in several years.

Remember, you need only one Medigap policy. It is illegal for insurance agents to sell consumers duplicate policies or use scare tactics to frighten consumers into dropping existing policies or purchasing policies they don't need or can't afford.

WHERE CAN I GO FOR MORE INFORMATION?

There are a number of publications that explain the various policy options. For a free, eight-page brochure describing the new Medigap laws and plans, send a self-addressed, business-size envelope with 52 cents postage to United Senior Health Cooperative, 1331 H. St., Dept N., Washington, D.C. 20005.

To receive a free copy of *A Consumer's Guide to Medicare Supplement Insurance* write to Health Insurance Association of America, P.O. Box 41455, Washington, D.C. 20018.

Medicare Supplement Insurance Approved Policies explains the additional requirements for Wisconsin policies. To get a free copy of this book, write to the State of Wisconsin, Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wis. 53707-7873.

THE MEDICARE PATIENT'S HOSPITALIZATION GUIDE

In 1983, in order to simplify reimbursement, the federal government divided over 450 medical procedures into Diagnostic Related Groups or DRGs.

HOW DOES THE DRG SYSTEM AFFECT MY HOSPITAL STAY?

Under the DRG system, hospitals are paid a fixed amount per patient based on what Medicare determines is the average cost for patients with similar diagnoses. This amount does not change regardless of how sick you are or how long you stay in the hospital. As a result, a hospital can save money by cutting down on the cost of serving each patient or lose money if it keeps patients too long or provides them with care that is too intensive.

Since providing high-quality care — and avoiding

HEALTH CARE COST'S UNHEALTHY SQUEEZE ON OLDER AMERICANS

In 1991, America's elderly spent more than twice as much money on health care (almost 18 times in inflation-adjusted dollars) as they did in 1961. In that year, out-of-pocket costs averaged \$1,589 per elderly family. By 1991, those costs had reached \$3,305 (see table). That's 17 percent of the average family's after-tax income. Twelve percent of that amount is paid directly to health care providers; the remaining 5 percent goes to insurance companies. And this amount does not even include the increased taxes that elderly families must pay to support government health programs. These ever-increasing health care costs have over time tightened the squeeze on the American family and there's no relief in sight, making the need for health care reform more urgent than ever.

Elderly family out-of-pocket health expenditures (1991 dollars)

| | 1961 | 1991 |
|--|---------|---------|
| PER FAMILY OUT-OF-POCKET EXPENDITURES | | |
| Total | \$1,589 | \$3,305 |
| Direct out-of-pocket | 1,285 | 2,332 |
| Hospital | 228 | 90 |
| Physician | 316 | 408 |
| Nursing home | 287 | 1,194 |
| Other | 454 | 640 |
| Insurance | 304 | 973 |
| Private insurance | 304 | 653 |
| Medicare premium | NA | 320 |

PERCENT OF AFTER-TAX INCOME

| | 1961 | 1991 |
|----------------------|-------|-------|
| Total | 10.6% | 17.1% |
| Direct out-of-pocket | 8.6 | 12.1 |
| Insurance | 2.0 | 5.0 |
| Private insurance | 2.0 | 3.3 |
| Medicare premium | NA | 1.7 |

HEALTH PAGES



complications — is often the best way to get patients out of the hospital quickly, the DRG system does not necessarily reduce the quality of care patients receive. Studies have shown that hospitals are not releasing patients "quicker and sicker" since the DRG system went into effect.

HOW MUCH WILL I PAY?

Reimbursement is based on benefit periods. A benefit period starts when you first enter a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods covered under Medicare.

From Day 1 - Day 60 in each benefit period, Medicare pays for all covered services except the first \$676 (the insurance deductible). The hospital may only charge you the deductible for your first admission in each benefit period.

From Day 61 - Day 90 during each benefit period, Medicare pays for all covered services except for \$163 a day.

What happens on day 91? Medicare includes an extra 60 hospital days—reserve days—which you can use if you are hospitalized for more than 90 days. Once you use a reserve day you never get it back. Unlike your 90 hospital days in each benefit period, reserve days are not renewable.

Medicare pays for all covered services except \$326 a day for each reserve day you use. You are responsible for this amount.

THE MEDICARE PATIENT'S GUIDE TO PHYSICIAN PARTICIPATION

Most doctors will treat Medicare patients. However, doctors can choose whether or not to accept Medicare's allowable charge schedule. If a doctor chooses to always accept what Medicare is willing to pay, then the doctor is called a Medicare participating physician. In other words, a Medicare participating physician agrees to Accept Medicare Assignment. How

much you will have to pay depends on whether or not the doctor accepts assignment.

WHEN THE DOCTOR ACCEPTS MEDICARE ASSIGNMENT

If there is a "Yes" next to the doctor's name under the Accepts Medicare Assignment column in our listings, then you pay 20 percent of the doctor's charge and no more.

WHEN THE DOCTOR DOES NOT ACCEPT MEDICARE ASSIGNMENT

If there is a "No" next to the doctor's name under the Accepts Medicare Assignment column in our listings, you will be responsible for paying not only 20 percent of the doctor's charge, but also the amount that is above Medicare's highest allowable charge. (See the table below to help you calculate your out-of-pocket expense.)

CAN I ASK MY DOCTOR TO ACCEPT ASSIGNMENT?

Absolutely. If a doctor does not accept Medicare assignment, it means that he or she has not agreed in advance to accept Medicare assignment for all patients. But these doctors may accept assignment for individual patients and often do if a patient asks.

CAN THE DOCTOR CHARGE ME ANY PRICE HE OR SHE WANTS?

Until 1990 a doctor could charge whatever he or she deemed fair. Then, the federal government enacted a law that imposes limits on what physicians and other health care professionals can bill for services provided to Medicare patients. As of January 1, 1993, health care professionals may not charge more than 15 percent above Medicare's maximum, or allowable rate.

HOW ASSIGNMENT SAVES YOU MONEY

| | |
|---------------------------------------|---|
| Doctor's fee is: | \$575 |
| Medicare's allowable fee is: | \$500 |
| Medicare pays the doctor: | \$400 (80% of \$500) |
| WITH Assignment you pay: | \$100 (20% of \$500) |
| WITHOUT Assignment you pay: | \$175 (20% of \$500 PLUS the entire difference between Medicare's allowable fee and the doctor's fee) |
| Total Savings with Assignment: | \$75 |

House Calls

What You Should Know About Home Health Services

As the saying goes, "There's no place like home." Although there are times when the medical resources and round-the-clock attention of a hospital or rehabilitation facility are needed to provide maximum care for a patient, there are other times when the familiar surroundings of a person's own home and the loving presence of family members can help to speed recovery or ease the transition at the end of a person's life.

Many acute care services are now available at home for people discharged from the hospital. Home health providers are helping the chronically ill, aged and disabled regain and retain their independence. It is important to note that home care is not just for the elderly. It can be a major help for people of all ages, including children and families. In fact, one out of every four people currently receiving home care is under age 65.

WHAT SERVICES ARE AVAILABLE?

Home care services can range from fairly sophisticated high tech care (similar to what a patient would get in a hospital) to help with the activities of daily living such as housecleaning and meal preparation. Each person's home care program must be tailored to match his or her needs with appropriate services. A variety of home care workers could be involved in an individual's plan for home care services. The two main types of home care:

- **Rehabilitative home care** is provided to people who are convalescing from an illness or are in a rehabilitation program. Many of these patients have been recently discharged from a hospital. The rehabilitative health care team may include a physician, nurse, nutritionist, homemaker, home health aide and various therapists.

Skilled Nursing is the most common rehabilitative

home care service. Nurses change dressings, administer drugs and monitor patients for complications or serious changes in health. They also teach newly discharged hospital patients and their families how to perform skilled nursing procedures so they can eventually perform these procedures.

Nurses are divided into two groups: *registered nurses*, or RNs; and *licensed practical nurses*, or LPNs. RNs, who hold a four-year college nursing degree or BSN (Bachelor of Science in Nursing), are trained to make independent judgments about a patient's condition and care, and can perform basic patient examinations. LPNs undergo much shorter training that focuses on mastering routine nursing tasks.

Therapists make up another part of the spectrum of home health care providers. Their role: To restore, maintain or enhance the abilities of those under their care. There are several different types of therapy. Physical therapy focuses on enhancing physical movement. Speech therapy works on communication problems. Occupational therapy helps people overcome problems of daily living at home or at work.

- **Basic home care** refers to the kinds of services provided to patients who otherwise might be unable to remain at home because of a disabling health condition. Continued health supervision with an emphasis on health promotion enables these patients to maintain both a stable state of health and relative independence.

Homemaker and home health aide services are the least expensive home care service. Many of the recipients of such care have a chronic illness or disability.

Homemakers, or companions, are responsible for a wide variety of tasks that keep the home clean and safe, and generally contribute to a person's well-being. These include basic housekeeping (tidying rooms, vac-

HEALTH PAGES

uuming, making and changing the bed, preparing and serving meals, shopping for food) and personal care (helping patients to wash and dress).

Home health aides perform three general services: (1) personal care (2) basic nursing (3) incidental home-making. An aide cannot provide skilled nursing care. For example, although an aide can take and record your temperature, pulse and respiration rate, and make sure you follow simple medical recommendations such as getting more exercise, he or she generally cannot administer drug injections.

IS HOME CARE FOR YOU?

The first step in determining whether home care is appropriate for you is to discuss the issue with your physician. Make sure your doctor knows you are willing to work with him or her to reach a decision on home care. You can also evaluate options with a hospital discharge planner, whose job it is to discuss local home care services with you.

If home care is deemed appropriate, your home care agency will conduct an *assessment*. This is a detailed evaluation of your situation that confirms the need for services ordered and identifies any other beneficial services. The assessment is usually made by an RN either in the hospital or at home. The agency then tailors a home care plan to your needs and reviews it

with you. Before finalizing the plan, the agency advises your doctor of its assessment and presents the plan for your doctor's approval. The plan outlines key details, including treatment goals, the specific services and level of care that will be provided, and any medical equipment and supplies that may be needed.

HOW DO I PAY FOR HOME CARE?

Some agencies are certified by Medicare to provide services to Medicare patients. To find out whether you or someone you love qualifies for home health services under Medicare, talk to the hospital discharge planner or your doctor, or call the agency directly. For those patients who are not covered by Medicare, most home health agencies accept reimbursement from private insurance companies or from the patient directly.

To be eligible for Medicare paid visits, a patient must first qualify for skilled care, such as that provided by a RN. Medicare does not cover home health care services limited to assistance with bathing, dressing and/or feeding. If a Medicare patient qualifies for service under the Medicare guidelines, Medicare is billed directly; a bill is usually not sent to the patient. In some instances, though—for example, when the patient is not homebound—Medicare will pay 80 percent of the cost, leaving the patient responsible for the remaining 20 percent.

■ All Saints Community Homecare and Hospice, Racine

CONTACT: Debra Ostroski
OWNERSHIP: St. Luke's affiliate
YEARS IN BUSINESS: 7

NURSING SERVICES

RN: \$75/visit LPN: \$75/visit
HOME HEALTH AIDES: Yes

THERAPISTS

PHYSICAL: \$75/visit SPEECH: \$75/visit
OCCUPATIONAL: \$75/visit

OTHER HOME SERVICES

COMPANION: Yes

PRIVATE DUTY SERVICES

HOSPITAL: Yes

HOSPICE CARE: Yes

PAYMENT: Medicare/Medicaid

■ ANEW Health Care Services, Wauwatosa

CONTACT: Sally Sprenger
OWNERSHIP: Local private
YEARS IN BUSINESS: 10

NURSING SERVICES

RN: \$80/visit LPN: Yes
HOME HEALTH AIDES: Yes

THERAPISTS

PHYSICAL: \$90/visit SPEECH: \$90/visit
OCCUPATIONAL: \$90/visit

OTHER HOME SERVICES

COMPANION: Yes LIVE-INS: Yes
TRANSPORTATION: Yes

PRIVATE DUTY SERVICES

HOSPITAL: \$30-40/hour

PAYMENT: Medicare/Medicaid

■ Camillus CARES Home Health, Wauwatosa

CONTACT: Sharon Pfeifer
OWNERSHIP: St. Camillus Campus
YEARS IN BUSINESS: 7

NURSING SERVICES

RN: \$70/visit
HOME HEALTH AIDES: Yes

THERAPISTS

PHYSICAL: \$75/visit SPEECH: \$75/visit
OCCUPATIONAL: \$75/visit

OTHER HOME SERVICES

COMPANION: \$10/hour
TRANSPORTATION: Yes

PRIVATE DUTY SERVICES

HOSPITAL: Yes

HEALTH PAGES

NURSING HOME: Yes

PAYMENT: Medicare/Medicaid

■ Horizon Home Care and Health Staffing, Milwaukee

CONTACT: Mary Ann Wolkomir
OWNERSHIP: Columbia Hospital affiliate

YEARS IN BUSINESS: 2

NURSING SERVICES

RN: \$43/hour LPN: \$26/hour
HOME HEALTH AIDES: \$17-24/hour

THERAPISTS

PHYSICAL: \$85/hour SPEECH: \$85/hour
OCCUPATIONAL: \$85/hour

OTHER HOME SERVICES

COMPANION: \$11-13/hour
LIVE-INS: \$168/day

PRIVATE DUTY SERVICES

HOSPITAL: \$16-26/hour
NURSING HOME: \$16-26/hour

HOSPICE CARE: Yes

PAYMENT: Medicare/Medicaid

■ Interim Healthcare, Madison

CONTACT: David Utter
OWNERSHIP: Local private
YEARS IN BUSINESS: 15

NURSING SERVICES

RN: \$32-35/hour LPN: \$25-26/hour
HOME HEALTH AIDES: \$14-16/hour

OTHER HOME SERVICES

COMPANION: \$13-15/hour

PRIVATE DUTY SERVICES

HOSPITAL: \$13-15/hour
NURSING HOME: \$13-15/hour

PAYMENT: Medicare/Medicaid

■ Jefferson Home Health Care, Madison

CONTACT: Bill Hamilton
OWNERSHIP: Local private
YEARS IN BUSINESS: 8

NURSING SERVICES

RN: \$29/hour LPN: \$24/hour
HOME HEALTH AIDES: \$19/hour

THERAPISTS

PHYSICAL: Yes SPEECH: Yes
OCCUPATIONAL: Yes

OTHER HOME SERVICES

COMPANION: Yes LIVE-INS: Yes

HOSPICE CARE: Yes

PAYMENT: Medicare/Medicaid

■ Midwest Medical Homecare, Brookfield

CONTACT: Michael Conway
OWNERSHIP: Local private
YEARS IN BUSINESS: 19

NURSING SERVICES

RN: \$40/hour LPN: \$30/hour
HOME HEALTH AIDES: \$16-19/hour

THERAPISTS

PHYSICAL: \$80/visit SPEECH: \$80/visit
OCCUPATIONAL: \$80/visit

OTHER HOME SERVICES

COMPANION: \$11/hour

PRIVATE DUTY SERVICES

HOSPITAL: \$16-40/hour
NURSING HOME: \$16-40/hour

PAYMENT: Medicare/Medicaid

■ St. Francis Home Health, Milwaukee

CONTACT: Lori Paprocki
OWNERSHIP: St. Francis Hospital affiliate
YEARS IN BUSINESS: 6

NURSING SERVICES

RN: \$85-90/visit
HOME HEALTH AIDES: \$20-22/hour

THERAPISTS

PHYSICAL: \$85-90/visit SPEECH: \$85-90/visit
OCCUPATIONAL: \$85-90/visit

PAYMENT: Medicare/Medicaid

■ St. Vincent Hospital Home Health Care, Green Bay

CONTACT: Joan Lindem
OWNERSHIP: St. Vincent Hospital
YEARS IN BUSINESS: 8

NURSING SERVICES

RN: \$88/visit LPN: \$88/visit
HOME HEALTH AIDES: \$51/visit

THERAPISTS

PHYSICAL: \$86/visit SPEECH: \$86/visit
OCCUPATIONAL: \$90/visit

■ Selon Health Care Services, Milwaukee

CONTACT: Mary Colla
OWNERSHIP: Daughters of Charity affiliate
YEARS IN BUSINESS: 10

NURSING SERVICES

RN: \$90/visit LPN: \$30/hour
HOME HEALTH AIDES: \$27/hour

THERAPISTS

PHYSICAL: \$95/visit SPEECH: \$95/visit
OCCUPATIONAL: \$95/visit

HOSPICE CARE: Yes

PAYMENT: Medicare/Medicaid

■ VNA of Greater Waukesha, Waukesha

CONTACT: Elizabeth Jensen
OWNERSHIP: Waukesha Hospital affiliate
YEARS IN BUSINESS: 45

NURSING SERVICES

RN: \$75/visit LPN: \$75/visit
HOME HEALTH AIDES: \$23/hour

THERAPISTS

PHYSICAL: \$84/visit SPEECH: \$84/visit
OCCUPATIONAL: \$84/visit

OTHER HOME SERVICES

COMPANION: \$12/hour

HOSPICE CARE: Yes

PAYMENT: Medicare/Medicaid

■ We Care Services, Madison

CONTACT: Carolyn Johnson
OWNERSHIP: Local private
YEARS IN BUSINESS: 3

OTHER HOME SERVICES

COMPANION: \$12.50/hour

PAYMENT: Medicare/Medicaid

Your Child's Tonsils – In or Out?

Not very long ago, if a child had a couple of sore throats, a trip to the hospital was in order, and his or her tonsils and adenoids would be surgically removed in a tonsillectomy and adenoidectomy. But thanks to new information about the role of tonsils and the

availability of improved antibiotics to treat tonsil infections, tonsillectomies have become far less common.

WHAT ARE TONSILS AND ADENOIDS?

The tonsils are a pair of small almond-shaped structures on either side of the throat just behind and above the tongue. Tonsils act as a defense against infections that invade the body through the nose and mouth. They are part of the lymphatic system of the body, a protective system whose cells attack and literally devour bacteria. Adenoids are tissue located at the back of the nose, above the tonsils. They, too, help protect against respiratory-tract infections.

WHAT IS TONSILLITIS?

Tonsillitis is an infection of the tonsils that children often come down with between the ages of three and six. When infected, tonsils become greatly enlarged, almost meeting in the middle of the throat. They turn fiery red and may have white spots on them. Occasionally, the adenoids swell too, lending a nasal quality to the child's voice. Since the symptoms of tonsillitis are similar to those of the flu—severe sore throat and a fever—it may be difficult to distinguish between the two. If the symptoms last more than 48 hours or your child has a history of

tonsillitis, see your pediatrician. He or she will examine your child's throat and probably take a throat culture. If tonsillitis is diagnosed, your doctor will probably prescribe a 10-day supply of an antibiotic, which will usually clear up the symptoms in a few days.

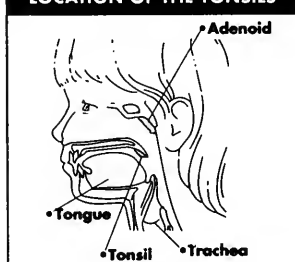
WHEN IS A TONSILLECTOMY AND ADENOIDECTOMY CALLED FOR?

Tonsils and adenoids are generally removed when they become so enlarged that they obstruct breathing, distort speech, or cause swallowing difficulties that result in weight loss and poor nutrition. Doctors may also recommend surgery for chronic, severe or stubborn tonsillitis that doesn't clear up. The operation is usually performed when a child is six or seven.

WHAT EXACTLY IS A TONSILLECTOMY AND ADENOIDECTOMY?

Tonsillectomy and adenoidectomy is a surgical procedure requiring general anesthesia, in which the tonsils and adenoids are cut away and the cut area is left to heal naturally. It is a simple operation but like all surgery, it involves a small amount of risk. The procedure can be performed either in a hospital, which requires a stay of a day or two, or in an outpatient surgical room, with rehabilitation occurring at home. You can expect your child's throat to be very sore for several days after the operation. Soft foods, including custards, soups, and especially ice cream, can help soothe the pain. You can tell your child that he or she can look forward to playing as usual and going back to school within a week after the operation.

LOCATION OF THE TONSILS



HEALTH PAGES

| YOUR GUIDE TO ENT SPECIALISTS | | | | |
|-------------------------------|---------------------|--|---|------------------------------|
| Doctor | Board Certification | Tonsillectomy & Adenoidectomy Under Age 12 | Tonsillectomy & Adenoidectomy Over Age 12 | Primary Hospital Affiliation |
| GREEN BAY | | | | |
| Dodds, Brian | 1990 | 5535 | 5535 | |
| Mills, John M. | 1967 | 456 | 456 | St. Vincent's |
| Schmidt, Frederick | 1989 | 456 | 456 | |
| Titulaer, Richard | 1975 | 535 | 535 | |
| Vander, Waude | 1972 | 456 | 456 | |
| Wineinger, David | 1969 | 456 | 456 | |
| MILWAUKEE | | | | |
| Anderson Jr., Ashley | 1982 | 600 | 600 | Meriter |
| Donovan, Timothy J. | 1970 | 716 | 662 | St. Mary's |
| Finch, William Wesley | 1978 | 600 | 600 | Meriter |
| Ford, Charles N. | 1971 | 660 | 610 | University of WI |
| Scott, John Kimball | 1959 | 600 | 600 | Meriter |
| Stanley, Robert John | 1988 | 716 | 662 | St. Mary's |
| MILWAUKEE | | | | |
| Barton, James Robert | 1980 | 525 | 525 | St. Luke's-Milw |
| Belson, Thomas Patrick | 1971 | 400 | 400 | Waukesha |
| Condon, Kenneth Gerard | 1988 | 515 | 588 | Waukesha |
| Damick, Steven Kie | 1987 | 525 | 525 | St. Luke's-Milw |
| Darling, William Anthony | 1976 | 400 | 400 | Waukesha |
| Durkin, Gretchen Elizabeth | 1988 | 510 | 530 | St. Mary's-Milw |
| Friedman, Jerry Eli | 1966 | 491 | 536 | Children's |
| Gruke, Richard John | 1983 | 475 | 475 | Menomonee |
| Janewak, Michael Charles | 1978 | 420 | 420 | Oconomowoc |
| Kidder, Thomas | 1973 | 511 | | Froedheri |
| Kleiser, Harvey | 1977 | 491 | 535 | Children's |
| Martimelli, Dean Louis | 1976 | 428 | 478 | Oconomowoc |
| Park, John Raymond | 1973 | 420 | 420 | Elmbrook |
| Wernwerth, Douglas John | 1989 | 450 | 450 | Columbia |
| ASTORIA GRABER | | | | |
| | | 521 | 522 | |

THE TRUTH ABOUT TONSILS

When it comes to tonsillectomies, it's hard to figure out where the myths end and the facts begin. Don't try to talk your doctor into removing your child's tonsils on the basis of any of these misconceptions:

• **"Tonsils are useless."** Not true. Medical scientists continue to report new evidence that shows tonsils are a valuable part of the body's defense mechanism against invading germs and viruses.

• **"My child is always sick."** Chances are your child is going through a normal stage of growth, irrespective of the condition of his or her tonsils. Before a child can build up his or her own antibodies to fight off disease agents, he or she must be exposed to them. So, a certain number of mild respiratory diseases are to be expected during a child's early years.

• **"He'll be healthier with them out."** It's a myth that a tonsillectomy and adenoidectomy makes a child less susceptible to colds, sore throats and other respiratory diseases. Nor does the operation relieve an allergy such as asthma.

• **"They're swollen."** What you perceive as swelling may be the tonsils' normal size. Tonsils are very small at birth, then enlarge gradually, reaching maximum size at age six or seven. Thereafter, they usually shrink to walnut size. Adenoids grow between the ages of three and five and then shrink, eventually disappearing altogether during puberty. Unless a medical problem is diagnosed, enlargement alone is no basis for surgery.

HEALTH PAGES

| TONSILLECTOMY & ADENOIDECTOMY | | | | |
|------------------------------------|---------------------|----------------|---|----------------|
| HOSPITALS | | | | |
| | Inpatient Procedure | | Procedure Performed on Outpatient Basis | |
| | Number of Patients | Average Charge | Number of Patients | Average Charge |
| GREEN BAY | | | | |
| Bella Memorial | | | | |
| St. Mary's | 76 | \$1,725 | 63 | \$1,584 |
| St. Vincent | 39 | 1,547 | 249 | 1,325 |
| MADISON | | | | |
| Meriter | 145 | 1,911 | | |
| St. Mary's | 65 | 1,338 | | |
| University of WI | 27 | 2,724 | | |
| MILWAUKEE | | | | |
| Burlington-Memorial | | | 52 | 1,831 |
| Children's Hosp of WI | 157 | 4,241 | 174 | 1,818 |
| Columbia | | | | |
| Elmhurst Memorial-Brookfield | | | 35 | 1,543 |
| Froedtert Memorial | | | | |
| Lakeview | | | 48 | 1,119 |
| Menomonie Falls-Community Memorial | | | 89 | 867 |
| Milwaukee County Medical | | | | |
| Northwest General | | | | |
| Oconomowoc-Memorial | 69 | 2,154 | | |
| St. Francis | | | 31 | 1,210 |
| St. Joseph's | 42 | 1,535 | | |
| St. Luke's-Milwaukee | | | 47 | 974 |
| St. Luke's-Racine | | | | |
| St. Mary's-Milwaukee | 41 | 1,876 | | |
| St. Mary's-Ozaukee | | | | |
| St. Michael | | | 40 | 2,163 |
| Sinai Samaritan | | | | |
| Trinity | | | | |
| Waukesha Memorial | 109 | 2,302 | 32 | 1,857 |
| West Allis Memorial | | | 47 | 1,422 |
| AVERAGE CHARGE | | 2,539 | | 1,579 |

Source: Market Share Modeling, Inc., Lake Mills, WI

Weighty Matters

Superstars' Diet Secrets! Shed Pounds the Rich and Famous Way!" shouts the headline. Your hand reaches out. How did Liz... Forget it. There are no tricks, no secrets, no miracles. Losing weight is hard work. The people who succeed are the ones who see through the hokum and false promises.

In the 1980s, obesity went from being seen as a purely cosmetic problem to being designated a health risk. As a result, the past decade has been a boom period for the weight-loss industry. A host of companies rushed in offering miracle "cures" for the new disease. Even Oprah Winfrey got swept up in the hoopla—boasting to television viewers about her 67-pound weight loss thanks to one of these programs.

Since then a number of research studies have questioned the success claims of diet programs. A National Institute of Health conference on diet, for example, concluded that there was often "no data with which to answer questions about voluntary weight loss and control methods." The limited data there was suggested that many people who complete commercial diets can expect to regain one-third of their lost weight after one year, two-thirds or more after three years and 90 to 95 percent in three to five years.

Around the same time, the Federal Trade Commission (FTC) began investigating the diet industry's claims of success. As a result of this investigation, which did not find research to support the claims, the FTC is thinking of recommending that center-based diet programs be required to keep accurate statistics about the number of people who enroll, the length of their participation, the rate of weight loss and the amount of time that weight loss is maintained.

These research findings along with Oprah's gradual return to her former weight have had their effect. Many weight loss programs have gone out of business; others have seen their demand plummet by 50 percent or more.

Still, that doesn't mean you shouldn't reduce your calorie intake if you need to. Some medical conditions, like an elevated cholesterol level, hypertension and adult-onset diabetes are exacerbated by being overweight. Losing 10 to 15 percent of your starting weight (at your doctor's recommendation) will often significantly reduce your health risk, even if you are still considerably above your weight goal. Remember,

even if your expectations aren't met, your weight loss program may still be considered "successful."

It's important to have reasonable expectations for any diet program. If you expect that losing weight will solve all your problems, like finding that special partner or getting a new job, you're setting yourself up for trouble. Chances are you'll just get frustrated and go back to your old eating and exercise habits if your problems aren't solved.

HOW MUCH SHOULD I WEIGH?

Not every woman can look like Cindy Crawford. Nor should she try to. Your body type and the weight that is biologically appropriate for you are determined primarily by genetics. Any adjustments—up or down—are somewhat limited by your biological heritage. Consequently, more and more physicians and researchers are recommending that people aim for their "natural weight" rather than a goal or ideal weight. In general, natural weight is achieved when a person eats normally (about 1,800 calories a day for a woman and 2,200 calories a day for a man) and exercises regularly—the equivalent of a brisk one-hour walk each day.

If you are interested in losing weight it is important to understand that diet is only one part of the equation. Although there are a number of weight loss programs that have proved to be very successful, with people shedding many pounds in a short time, the problem is keeping the weight off. Studies have shown that the people most likely to maintain their weight loss are not those who are the best dieters, but those who supplement their diet program with an exercise routine and continue to exercise regularly after reaching their goal weight. Experts say that establishing new eating and exercising habits is the real key to long-term weight maintenance—and the only hope for breaking the yo-yo diet syndrome.

■ Behavioral Weight Management Services, Milwaukee

CONTACT: Lynn Fischer, R.N.
OWNERSHIP: St. Luke's Medical Center

INSTRUCTORS: Dietitians, Psychologists & Nurses
BEHAVIOR CLASSES (AVG. SIZE): 8 - 10
AVERAGE TIME: 90 min.

PROGRAM LENGTH: 10-25+ weeks
COST/WEEK: \$27

LIQUID DIET: Optifast
AVERAGE COST/WEEK: \$60

MAINTENANCE CLASS: Individual and group meetings (\$32-41)

EXERCISE CLASS: Weight (\$30)

■ Bellin Health Connection, Green Bay

OWNERSHIP: Bellin Memorial

PROGRAM LENGTH: Nutrition Class/8 wks/\$60; Adult Weight Control/10 wks/\$65; Children Weight Control/10wks/\$100

EXERCISE CLASS: Fitness center and aerobic classes (\$210/year)

■ Burlington Weight Control Center

CONTACT: Jan Caffisch
OWNERSHIP: Memorial Hospital of Burlington

INSTRUCTORS: Nutritionists
BEHAVIOR CLASSES (AVG. SIZE): 6
AVERAGE TIME: 60-90 min.

PROGRAM LENGTH: Individual counseling plus 6 weeks of

nutrition classes and 12 weeks of behavior modification classes
COST/WEEK: \$25

LIQUID DIET: LightSource
AVERAGE COST/WEEK: \$23-46

PREPARED MEALS: Back to Basics
AVERAGE COST/MEAL: \$3.75

MAINTENANCE CLASS: 12 weeks (Free)

EXERCISE CLASS: Low impact aerobics (\$20/four weeks)

■ Diet Center, Milwaukee

CONTACT: Karolyn Anderson
OWNERSHIP: Franchise

INSTRUCTORS: Nutritionists

PROGRAM LENGTH: Individual counseling

■ Embody, Madison

OWNERSHIP: Meriter Hospital

INSTRUCTORS: Exercise Physiologists, Dietitians

BEHAVIOR CLASSES (AVG. SIZE): 12 - 15
AVERAGE TIME: 30 min.

PROGRAM LENGTH: 12 weeks of behavior and exercise classes
COST/WEEK: \$23

■ Nutrition and Weight Control Clinic, Milwaukee

CONTACT: Jan Howard
OWNERSHIP: St. Michael Hospital

INSTRUCTORS: Dietitians

PROGRAM LENGTH: Individual instruction; \$76 first meeting,

\$19/15 min. follow-ups

■ Point System Diet, West Allis

OWNERSHIP: West Allis Memorial

INSTRUCTORS: Dietitians

BEHAVIOR CLASSES (AVG. SIZE): 7 - 8
AVERAGE TIME: 90 min.

PROGRAM LENGTH: Classes plus individual counseling-program length open to individual needs
COST/WEEK: \$25

■ Think Light-Lowfat Living Plan, Racine

CONTACT: Julie Dickert
OWNERSHIP: St. Luke's Hospital

INSTRUCTORS: Dietitians
BEHAVIOR CLASSES (AVG. SIZE): 18
AVERAGE TIME: 120 min.

PROGRAM LENGTH: 10 weeks
COST/WEEK: \$12.50

MAINTENANCE CLASS: Support Group (Free)

■ Weight Management Program, Menomonee Falls

CONTACT: Shawn Seurce
OWNERSHIP: Community Memorial Hospital

INSTRUCTORS: Dietitians
BEHAVIOR CLASSES (AVG. SIZE): 7
AVERAGE TIME: 90 min

PROGRAM LENGTH: 6 weeks
COST/WEEK: \$70 total fee

MAINTENANCE CLASS: 6 weeks (\$35)

■ Weight Watchers

INSTRUCTORS: Previous Weight Watchers' members
AVERAGE CLASS SIZE: 30-40
AVERAGE TIME: 60 min.

PROGRAM LENGTH: Weekly meetings until goal is reached
COST/WEEK: \$11

MAINTENANCE CLASS: Meetings (free if at goal weight, otherwise \$11)

Guidelines for Doctors and Patients

Doctors receive no shortage of advice when it comes to treating patients. But now a new authoritative voice is distinguishing itself from the crowd, representing the opinions of experts backed by the Federal Government.

The Agency for Health Care Policy and Research, established by Congress in 1988, has been charged with finding out what the nation gets for the billions of dollars it spends annually on health care as well as what can be done to improve the quality of care provided. What investigators found was a tremendous variation across the country, even within a single community, in how doctors treat different illnesses, sometimes to the patient's detriment.

As a result, in March 1992, the agency began issuing guidelines that outline the best ways for doctors, nurses and other healthcare providers to treat certain conditions that affect large numbers of Americans.

The agency itself does not develop the guidelines; it

convenes an expert panel of outside physicians and researchers to do so. For example, in constructing the pain control guidelines below, the appointed panel critically examined 11,000 scientific sources of information to determine the state-of-the-art in pain

management. Before the guidelines were released, they were tested in hospitals and clinics across the nation to ensure their clarity and applicability.

When the pain control guidelines were made public, Dr. Louis Sullivan, then Health and Human Services Secretary, said that they mark "the beginning of a peaceful revolution in American medical care." The HEALTH PAGES believes that in order for the revolution to be successful, it is essential that you, the reader, learn about these guidelines. Consequently, as a regular feature, we will publish a summary of government findings. Among the areas we hope to cover in future issues: prostate enlargement, impairment from cataracts and lower back problems.

PAIN CONTROL AFTER SURGERY: A PATIENT'S GUIDE

Adapted from a booklet by the Agency for Health Care Policy and Research.

an agency of the U.S. Public Health Service. The complete guide is available free by calling (800) 358-9295.

What is pain?

Pain is your body's way of sending a warning message to your brain. Your spinal cord and nerves (there are thousands of receptor nerve cells in and beneath your skin) provide the pathway for messages to and from your brain and other parts of your body. Pain medication blocks or reduces the effect of these messages.

What role does pain control after surgery play?

Pain control can help you enjoy greater comfort while you heal, get well faster (with less pain you'll be able to do necessary breathing exercises, get your strength back, even leave the hospital sooner) and

improve results (people whose pain is well-controlled seem to do better after surgery and may avoid some problems, such as pneumonia and blood clots).

What are the options?

Severe pain after surgery is no longer something you "just have to put up with." Both drug and non-drug treatments before and after surgery can successfully help prevent or relieve pain. The most common methods of pain control: pain medication before surgery; general anesthesia, spinal anesthesia (nerve block) or an epidural (in which medication is administered through a small tube in your back), during

HEALTH PAGES

surgery; pain medication in pill, shot or suppository form or through a tube in your vein or back, massages, hot or cold packs, relaxation exercises, positive thinking and nerve stimulation (TENS) after surgery.

Many people combine two or more pain control methods. Since the amount or type of pain you feel may not be the same as what others feel—even those who've had the same operation—you and your caregivers will need to work together to choose the pain control methods that are right for you. If you're worried about getting "hooked" on pain medication, don't be. Studies show that this is rare unless you have a drug abuse problem to start with.

THE SEVEN STEP PAIN CONTROL PROGRAM

These guidelines for things you can do before and after surgery can help you help yourself keep pain under control.

Before Surgery

1. Ask your caregiver what to expect. Getting answers to questions such as "Will there be much pain after surgery?" "Where will it occur?" "How long is it likely to last?" will help you prepare for surgery and put you in control. Write down your questions before you meet with your caregiver.

2. Discuss pain control options with your caregiver. Talk about methods that have or haven't worked well for you in the past, mention any concerns you may have about pain medication, ask about treatment side effects and alert your caregiver to medication allergies as well as medicines you are taking for other health problems to avoid negative drug interactions.

3. Talk about the schedule for pain medicines in the hospital. Instead of waiting until pain breaks through to take medication, getting pain pills or shots at set times can help keep pain under control. Additionally, patient controlled analgesia (PCA) may be available at your hospital. With PCA you are in control, pressing a button to inject medicine through an intravenous (IV) tube in your vein when you begin to feel pain. Whichever method you choose, keep your caregiver abreast of how well it's working.

4. Work with your caregiver to create a pain control plan. Use the form (opposite) to begin planning for pain control with your caregiver—he or she needs your help to design the plan that's best for you. Refer to the form after your operation and keep it as a record in case you need surgery in the future.

After Surgery

5. Take (or ask for) pain relief drugs when pain first begins. Additionally, if you know the pain will worsen when you start walking or doing breathing exercises, take pain medication first. It's harder to ease pain once it has taken hold.

6. Help your caregiver "measure" your pain. He or she may ask you to rate your pain on a scale of 1 to 10 or to choose a word from a list that best describes the pain. Reporting your pain as a number helps your caregiver know how well the treatment is working and whether to make any changes. You may also set a number as a pain control goal.

7. Tell your caregiver about any pain that won't go away. Don't worry about being a bother. Pain can be a sign of problems with your operation and your caregiver will want to know about it. Also, if the pain control plan isn't working, your caregiver will want to change it.

PAIN CONTROL PLAN

Pain Control Plan For: _____

Before surgery, I will take

Name of medicine: _____

Instructions for use: _____

After surgery, I will take

Name of medicine: _____
in the hospital

The medicine will be given to me:

____ as a pill _____ through a vein
____ as a shot _____ through a tube in my back

I will receive the medicine:

____ at regularly scheduled times
____ every _____ hours for _____ days
____ around the clock _____ when I call the nurse

I will also use these non-drug pain control methods in the hospital and at home (list methods):

At home, I will take

Name of medicine: _____

Instructions for use: _____

Physicians' File

OB/GYN

GREEN BAY

Bechtel, Richard Jr.
MEDICAL SCHOOL: Duke Univ., 1966
INTERNSHIPS: Blodgett Memorial Hosp., Grand Rapids, 1967
RESIDENCIES: Duke Univ., 1971
FELLOWSHIPS: Duke Univ., 1969
COVERAGE GROUP: OB-GYN Associates of Green Bay
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Weekend
CREDIT CARDS: MC & Visa

Carvanough, Robert
MEDICAL SCHOOL: SIU School Medicine
INTERNSHIPS: SIU School Medicine
RESIDENCIES: SIU School Medicine
COVERAGE GROUP: OB-GYN Associates of Green Bay
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Weekends
CREDIT CARDS: MC & Visa

DeMott, Robert
MEDICAL SCHOOL: Univ of Wisconsin, 1981
INTERNSHIPS: Univ of Pittsburgh, 1982
RESIDENCIES: Univ of Pittsburgh, 1985
COVERAGE GROUP: OB-GYN Associates of Green Bay
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Weekends
CREDIT CARDS: MC & Visa

Mahoney, Thomas
MEDICAL SCHOOL: Univ of South Dakota, 1985
INTERNSHIPS: McLennan Hospital
RESIDENCIES: St. Joseph's Hosp., Milwaukee
COVERAGE GROUP: Webster Clinic
SERVICES: Circumcisions, Ultrasound, Venipuncture

Sandmire, Herbert
MEDICAL SCHOOL: Univ of Wisconsin, 1953
INTERNSHIPS: Beaumont Army Hospital, 1954
RESIDENCIES: Univ of Iowa Hosp., Iowa City, 1958
COVERAGE GROUP: OB-GYN Associates of Green Bay

SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Weekends
CREDIT CARDS: MC & Visa

Schweckler, Amy
MEDICAL SCHOOL: SUNY at Buffalo, 1984
INTERNSHIPS: Sisters of Charity Hosp
RESIDENCIES: SUNY at Buffalo
COVERAGE GROUP: Poley & Utrie
SERVICES: Circumcisions, Ultrasound, Venipuncture

Sehring, Frederick
MEDICAL SCHOOL: Med Coll WI, 1956
SERVICES: Ultrasound, Venipuncture

Sehring, Stephen
MEDICAL SCHOOL: Med Coll of WI, 1985
INTERNSHIPS: Emory Univ Affil Hosp
RESIDENCIES: Emory Univ Affil Hosp
COVERAGE GROUP: Frederick Sehring
SERVICES: Circumcisions, Ultrasound, Venipuncture

Shaffer, Richard
INTERNSHIPS: Wisconsin Hosp., 1973
RESIDENCIES: Wisconsin Hosp., 1976

Utrie, John
MEDICAL SCHOOL: Marquette Univ., 1959
INTERNSHIPS: Miller Hosp., St. Paul, 1960
RESIDENCIES: Affil Hospital, Minn., 1966

MADISON

Anderson, John
MEDICAL SCHOOL: Univ of Nebraska, 1967
INTERNSHIPS: Madison Gen Hosp., 1968
RESIDENCIES: Nebraska Hosp., 1973
COVERAGE GROUP: Roley, Roley & Torhorst
SERVICES: Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Baker, Robert Jr.
MEDICAL SCHOOL: Univ of Minnesota, 1962
INTERNSHIPS: Santa Clara Hosp., San Jose, 1963
RESIDENCIES: Univ of WI,

HOW TO READ THE PHYSICIAN LISTINGS

Medical School: A doctor's training requires a premedical undergraduate education and four years of medical school. The year in which his or her medical degree was granted can tell you how old the doctor is and how long ago his or her training was completed.

You may prefer a doctor who has just learned about the latest medical breakthroughs and techniques, or you may prefer a doctor who has had years of practical experience and has seen firsthand a vast range of medical problems. Of course, while a physician's formal medical training may have taken place

many years ago, he or she should still be up to date on current medical procedures through working with peers, keeping up with the journals and attending conferences.

Internship: An internship is a one or two year period of hospital training following graduation from medical school. During this training period, physicians are called interns.

Residency/Specialty: A residency is a post-internship hospital training period of two to six years at the end of which a doctor becomes a specialist. A specialist is a doctor who concentrates on certain body systems, specific age groups or certain techniques developed to

HEALTH PAGES

1969
COVERAGE GROUP:
 Physicians Plus
SERVICES: Ultrasound,
 Venipuncture
CREDIT CARDS: MC & Visa

Beck, James
MEDICAL SCHOOL: Univ of
 Wisconsin, 1963
INTERNSHIPS: Madison
 General Hosp, 1963
RESIDENCIES: St. Joseph's
 Hosp, Milwaukee, 1967
COVERAGE GROUP: Dean
 Medical

Christmann, Robert
MEDICAL SCHOOL: NY Med,
 1965
INTERNSHIPS: Albany Med
 Center Hosp, 1966
RESIDENCIES: Albany Med
 Center Hosp, 1969

Davidson, Susan
MEDICAL SCHOOL: Albert
 Einstein Coll of Med,
 1982
RESIDENCIES: Albert Einstein
 College of Medicine, 1986
FELLOWSHIPS: Maternal-
 Fetal Med, Univ of WI,
 1988
COVERAGE GROUP: Dean
 Medical
SERVICES: Circumcisions,
 Ultrasound

Danopoulos, Jean
MEDICAL SCHOOL: Univ of
 WI, 1980
INTERNSHIPS: Univ of WI
RESIDENCIES: Univ of WI
COVERAGE GROUP: Dean

Medical
SERVICES: Ultrasound,
 Venipuncture

Diam, Klaus
MEDICAL SCHOOL: Baylor
 Coll of Med, 1974
INTERNSHIPS: Univ of WI,
 1975
RESIDENCIES: Univ of WI,
 1978
COVERAGE GROUP:
 Physicians Plus
SERVICES: Circumcisions,
 Ultrasound, Venipuncture
HOURS: Weekend
CREDIT CARDS: MC & Visa

Droste, Sabine
MEDICAL SCHOOL: Univ of
 South Dakota, 1984
INTERNSHIPS: Univ of WI
RESIDENCIES: Univ of WI
FELLOWSHIPS: Maternal-
 Fetal Med, Univ of WA
COVERAGE GROUP: Univ OB-
 GYN Associates
SERVICES: Midwives,
 Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Estrin, Margaret
MEDICAL SCHOOL: Univ of
 Kansas, 1979
INTERNSHIPS: Univ of WI,
 1980
RESIDENCIES: Univ of WI,
 1983
COVERAGE GROUP:
 Hackforth-Jones & Stoffel
 (all female)
SERVICES: Ultrasound,
 Venipuncture
HOURS: Weekends

Fek, Joseph
MEDICAL SCHOOL: Univ of
 WI, 1978
INTERNSHIPS: Univ of WI,
 1979
RESIDENCIES: Univ of WI,
 1982
COVERAGE GROUP: Dean
 Medical
SERVICES: Ultrasound,
 Venipuncture
HOURS: Evening & Weekend

Hackforth-Jones, Jenny
MEDICAL SCHOOL: Univ of
 Michigan, 1982
INTERNSHIPS: Univ of WI
RESIDENCIES: Univ of WI
COVERAGE GROUP: Estrin &
 Stoffel (all female)
SERVICES: Ultrasound,
 Venipuncture
HOURS: Weekends

Henderson, Perry
MEDICAL SCHOOL: Western
 Reserve Univ, 1958
INTERNSHIPS: Cleveland
 Metropolitan General
 Hosp, 1959
RESIDENCIES: Cleveland
 Metropolitan General
 Hosp, 1965
FELLOWSHIPS: Univ WA,
 1968
COVERAGE GROUP: Univ
 OB/GYN Associates
SERVICES: Midwives,
 Circumcisions,
 Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Horzog, Paul
MEDICAL SCHOOL: State Univ
 Syracuse, 1964

INTERNSHIPS: Johns
 Hopkins Hosp, 1965
RESIDENCIES: Univ of WI,
 1969
COVERAGE GROUP:
 Physicians Plus
SERVICES: Ultrasound,
 Venipuncture
CREDIT CARDS: MC & Visa

Jackson, C. Robert
MEDICAL SCHOOL: Jefferson,
 1956
INTERNSHIPS: St. Mary's
 Hosp, Duluth, 1957
RESIDENCIES: Univ of WI,
 1961
COVERAGE GROUP:
 Physicians Plus
SERVICES: Ultrasound,
 Venipuncture
CREDIT CARDS: MC & Visa

Keller, Jr., William
MEDICAL SCHOOL: Ohio State
 Univ, 1970
RESIDENCIES: Univ of WI
 Hosp
COVERAGE GROUP: Dean
 Medical
SERVICES: Ultrasound,
 Venipuncture
HOURS: Evening &
 Weekends

Kraemer, Karen
MEDICAL SCHOOL: Mayo Med
 School, 1979
INTERNSHIPS: Univ of
 Colorado
RESIDENCIES: Univ of WI
COVERAGE GROUP: Dean
 Medical
SERVICES: Ultrasound,
 Venipuncture

diagnose or treat specific types of disorders. As a resident, a doctor gets full-time experience in a hospital caring for patients under the supervision of experienced teaching specialists.

Fellowship/Subspecialty: A fellowship is a period of one or more years of additional training in a more specific sub-area of a specialty undertaken by some physicians following their residencies. Upon completion of the fellowship the physician is granted sub-specialist standing. For example, oncology is a sub-specialty of internal medicine and pediatric surgery is a sub-specialty of surgery.

Services Available in the Doctor's Office: If ultrasound and blood-drawing services are provided in a doctor's office, it may save you a trip to the lab.

Evening/Weekend Hours: Some doctors have weekend or evening hours to accommodate patients' work schedules. Call the doctor's office for more information.

Certified Nurse-Midwife: These practitioners are registered nurses with a bachelor's degree in nursing and a master's or other advanced degree in maternal-child health. Midwives are generally chosen by women who want constant attention throughout the entire birth process—labor, delivery and recovery.

HEALTH PAGES

Müller, Kim

MEDICAL SCHOOL: Univ of WI, 1983
RESIDENCIES: Univ of Pittsburgh, 1987
COVERAGE GROUP: Physicians Plus
SERVICES: Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Roley, Everett

MEDICAL SCHOOL: Creighton Univ, 1956
INTERNSHIPS: USN Hosp, Chelsea, Mass, 1957
RESIDENCIES: Univ of WI, 1963
SERVICES: Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Roley, Kevin

MEDICAL SCHOOL: Creighton Univ, 1986
INTERNSHIPS: Univ of WI Affil Hosp
RESIDENCIES: Univ of WI Affil Hosp
COVERAGE GROUP: Anderson Roley, Torhorst
SERVICES: Circumcisions, Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Rudat, Karl

MEDICAL SCHOOL: Univ of WI, 1983
INTERNSHIPS: Med Coll Virginia, 1974
RESIDENCIES: Med Coll Virginia, 1977
COVERAGE GROUP: Dean Medical
SERVICES: Ultrasound, Venipuncture
HOURS: Evenings and Weekends

Rudman, Sherwin

MEDICAL SCHOOL: Univ of Illinois, 1974
INTERNSHIPS: Univ of Illinois Hosp, 1977
COVERAGE GROUP: Physicians Plus
SERVICES: Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

MILWAUKEE

Alman, Edward

MEDICAL SCHOOL: Marquette Univ, 1969
INTERNSHIPS: Kansas, 1970
RESIDENCIES: Med Coll WI, 1974

Alexander, A. Charles

MEDICAL SCHOOL: Northwestern Univ
INTERNSHIPS: Northwestern Univ
SERVICES: Circumcisions, Ultrasound
CREDIT CARDS: MC

Azueta, Ester

MEDICAL SCHOOL: Univ of the East, Philippines

Babbitt, Allen

MEDICAL SCHOOL: Univ of WI, 1964
INTERNSHIPS: Evanston Hosp, 1969
RESIDENCIES: Univ of WI, 1974
COVERAGE GROUP: Burstein, Nash
SERVICES: Circumcisions, Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Baccus, Donald

MEDICAL SCHOOL: Univ of Michigan, 1976
INTERNSHIPS: St. Joseph's Hosp, Milwaukee, 1977
RESIDENCIES: St. Joseph's Hosp, Milwaukee, 1980
SERVICES: Circumcisions, Ultrasound
HOURS: Evening

Bae, Ik Hak

MEDICAL SCHOOL: Kyungpook Univ (Taegu, Korea), 1963
INTERNSHIPS: Detroit General Hosp, 1966
RESIDENCIES: Detroit General Hosp, 1970
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Evenings

Bart, Carmela

MEDICAL SCHOOL: Univ of Illinois, 1979
INTERNSHIPS: Med Coll WI-Milwaukee Co Hosp, 1980
RESIDENCIES: Med Coll WI-Milwaukee Co Hosp, 1983

Borkowf, Harold

MEDICAL SCHOOL: Witwatersrand (Johannesburg), 1959
INTERNSHIPS: Queen Victoria Maternity Hosp, 1961
RESIDENCIES: Johns Hopkins Hosp, 1968

Brennan, John

MEDICAL SCHOOL: Marquette Univ, 1946
INTERNSHIPS: St. Joseph's Hosp., Milwaukee, 1947
RESIDENCIES: St. Joseph's Hosp., Milwaukee, 1953
COVERAGE GROUP: Finlayson
SERVICES: Circumcisions, Venipuncture
HOURS: Evenings & Weekends

Brockman, Lenora

MEDICAL SCHOOL: Univ SK, Canada, 1980
RESIDENCIES: Hennepin Co. Med, Minneapolis, 1981

Broekhuizen, Fredrik

MEDICAL SCHOOL: Univ of Utrecht, Netherlands, 1972
INTERNSHIPS: Univ of WI
RESIDENCIES: Univ of WI
COVERAGE GROUP: Univ of WI Physicians
SERVICES: Midwives, Circumcisions, Ultrasound, Venipuncture

Budarapa, Susseela

MEDICAL SCHOOL: Andhra (India), 1946
RESIDENCIES: Mt. Sinai Med Center, Milwaukee, 1982

Burch, Kim

MEDICAL SCHOOL: Med Coll WI, 1976
INTERNSHIPS: Med Coll WI, 1977
RESIDENCIES: Med Coll WI, 1980
COVERAGE GROUP: Medical Associates
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Evenings & Weekends
CREDIT CARDS: MC, Visa & Amex

Burstein, P. D.

MEDICAL SCHOOL: Univ of Michigan, 1972

INTERNSHIPS: Univ of WI, 1973
RESIDENCIES: Univ of WI, 1976
COVERAGE GROUP: Babbitt, Nash
SERVICES: Circumcisions, Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Castillo, Marcelo

MEDICAL SCHOOL: Univ Philippines, 1952
INTERNSHIPS: Univ Philippines
RESIDENCIES: Univ Philippines, 1958

Chambers, LaRoyce

MEDICAL SCHOOL: Univ of Michigan, 1970
INTERNSHIPS: Chicago Wesley Memorial Hosp
RESIDENCIES: Northwestern Univ
COVERAGE GROUP: OB/GYN Medical Services
SERVICES: Circumcisions, Ultrasound, Venipuncture

Clark, Douglas

MEDICAL SCHOOL: Ohio State Univ, 1961
INTERNSHIPS: Milwaukee County Hosp, 1962
RESIDENCIES: Ohio State Univ, 1965
FELLOWSHIPS: Ohio State Univ, 1966
COVERAGE GROUP: Medical Associates
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Evenings & Weekends
CREDIT CARDS: MC, Visa, & Amex

Claude, John

MEDICAL SCHOOL: Marquette Univ, 1953
INTERNSHIPS: St. Joseph's Hosp, Milwaukee, 1954
RESIDENCIES: Milwaukee County Gen Hosp, 1959
COVERAGE GROUP: Wilkinson Medical Clinic
SERVICES: Circumcisions, Ultrasound, Venipuncture
HOURS: Weekends & Evenings
CREDIT CARDS: MC & Visa

Coulter, Renee

MEDICAL SCHOOL: Med Coll WI, 1979

HEALTH PAGES

INTERNSHIPS: Med Coll WI, 1980
RESIDENCIES: Med Coll WI, 1984

COVERAGE GROUP:
 Milwaukee Medical Clinic
SERVICES: Ultrasound,
 Venipuncture
HOURS: Weekend
CREDIT CARDS: MC & Visa

Craft, Samuel
MEDICAL SCHOOL: Med Coll
 Wisc, 1976

INTERNSHIPS: Med Coll
 Wisc, Milwaukee, 1976-
 1977

RESIDENCIES: Mt. Sinai
 Hosp, Milwaukee, 1980-
 1983

COVERAGE GROUP: Dr.
 Heitman

Daloz, James
MEDICAL SCHOOL: Univ of
 Minnesota, 1969

INTERNSHIPS: St. Joseph's
 Hosp, Milwaukee, 1970

RESIDENCIES: St. Joseph's
 Hosp, Milwaukee, 1973

COVERAGE GROUP:
 Moreland OB/GYN
SERVICES: Circumcisions,
 Ultrasound, Venipuncture
HOURS: Evening
CREDIT CARDS: MC & Visa

Dedeker, Mark
MEDICAL SCHOOL: Univ of
 North Dakota, 1984

INTERNSHIPS: Mt. Sinai Med
 Center

RESIDENCIES: Univ of WI
SERVICES: Midwives,
 Circumcisions,
 Ultrasound, Venipuncture
HOURS: Evenings
CREDIT CARDS: MC & Visa

Diallo, Lynn Kaitter
MEDICAL SCHOOL: Med Coll
 of WI, 1974

INTERNSHIPS: St. Joseph's
 Hosp, Milw

RESIDENCIES: St. Joseph's
 Hosp, Milw

COVERAGE GROUP:
 Women's Care
SERVICES: Circumcisions,
 Ultrasound, Venipuncture

HOURS: Evenings
CREDIT CARDS: MC & Visa

Dolan, James
MEDICAL SCHOOL: Univ of
 Ireland, Galway, 1973

INTERNSHIPS: St. Joseph's
 Hosp, Milwaukee
RESIDENCIES: St. Joseph's
 Hosp, Milwaukee

SERVICES: Circumcisions,
 Ultrasound, Venipuncture

Earle, Sandra H.
MEDICAL SCHOOL: Rush Med
 Coll, 1983

RESIDENCIES: Cook County
 Hosp, Chicago

COVERAGE GROUP: Lakeside
 OB/GYN

SERVICES: Circumcisions,
 Ultrasound, Venipuncture

HOURS: Evening

Felt, Gary
MEDICAL SCHOOL: Med Coll
 of WI, 1984

INTERNSHIPS: Wayne State
 Affiliated Hospitals

RESIDENCIES: Wayne State
 Affiliated Hospitals

SERVICES: Ultrasound,
 Venipuncture

HOURS: Evenings &
 Weekends

CREDIT CARDS: MC & Visa

Finlayson, William
MEDICAL SCHOOL: Meharry
 Med Coll, 1953

INTERNSHIPS: Meharry Med
 Coll, 1954

RESIDENCIES: Meharry Med
 Coll, 1957

Fox, Brian
MEDICAL SCHOOL: Wayne
 Univ, 1979

INTERNSHIPS: Blodgett & St.
 Mary's Hosp, Grand
 Rapids, 1980

RESIDENCIES: Blodgett & St.
 Mary's Hosp, Grand
 Rapids, 1983

COVERAGE GROUP: Racine
 Medical Clinic

SERVICES: Circumcisions,
 Ultrasound, Venipuncture

CREDIT CARDS: MC & Visa

Gilman, Daniel D.O.
MEDICAL SCHOOL: Univ of
 Osteopathic Med, Des
 Moines, 1980

INTERNSHIPS: Riverside
 Osteopathic Hosp,
 Trenton, MI

RESIDENCIES: Riverside
 Osteopathic Hosp,
 Trenton, MI

COVERAGE GROUP: Univ of
 Wisconsin

SERVICES: Midwives,
 Circumcisions,
 Ultrasound, Venipuncture

CREDIT CARDS: MC & Visa

Gilman, Michael D.O.
MEDICAL SCHOOL: College of
 Osteo Med. and Surgery,
 1979, 1979

INTERNSHIPS: NW General
 Hosp, Milwaukee, 1980

RESIDENCIES: U Wisc-Mt.
 Sinai Hosp, Milwaukee,
 1984

Good, Jyoti
MEDICAL SCHOOL:
 Rangamaya Med Coll,
 India, 1971

INTERNSHIPS: St. John Hosp,
 Detroit, 1977

RESIDENCIES: Cook County
 Hosp, Chicago, 1981

SERVICES: Circumcisions

Grades, Elan
MEDICAL SCHOOL: Cebu Inst
 Med, 1972

INTERNSHIPS: St. John's
 Epis. Hosp, Brooklyn,
 1967

RESIDENCIES: Cook County
 Hosp, Chicago, 1981

Gryniewicz, Michael
MEDICAL SCHOOL: Marquette
 Univ, 1965

INTERNSHIPS: St. Joseph's
 Hosp, Milwaukee, 1966

RESIDENCIES: St. Joseph's
 Hosp, Milwaukee, 1971

SERVICES: Circumcisions,
 Ultrasound

HOURS: Weekend

Hendrich, Thomas
MEDICAL SCHOOL: Med Coll
 WI, 1964

INTERNSHIPS: Johns
 Hopkins Hosp, 1965

RESIDENCIES: Univ of Texas,
 1968

FELLOWSHIPS: Johns
 Hopkins Hosp, 1965

COVERAGE GROUP:
 Milwaukee Medical Clinic

SERVICES: Circumcisions,
 Ultrasound, Venipuncture

HOURS: Weekend

CREDIT CARDS: MC & Visa

Holtman, Timothy
MEDICAL SCHOOL: Chicago
 Med School, 1982

RESIDENCIES: Mt. Sinai
 Medical Center, Univ of

WI, 1987

COVERAGE GROUP: Dr. Craft
SERVICES: Circumcisions,
 Ultrasound, Venipuncture

HOURS: Evening

CREDIT CARDS: MC & Visa

Hoffbauer, Thomas
MEDICAL SCHOOL: Marquette
 Univ, 1956

INTERNSHIPS: Milwaukee Co
 Gen Hosp, 1957

RESIDENCIES: Milwaukee Co
 Gen Hosp, 1962

COVERAGE GROUP: Medical
 Associates

SERVICES: Ultrasound,
 Venipuncture

HOURS: Evenings &
 Weekends

CREDIT CARDS: MC, Visa &
 Amex

James, Janine
MEDICAL SCHOOL: Univ of
 Illinois, Chicago, 1979

INTERNSHIPS: Mt. Sinai
 Hosp, Chicago, 1980

RESIDENCIES: Mt. Sinai
 Hosp, Chicago, 1982

FELLOWSHIPS: Univ of
 Illinois, 1985

SERVICES:
 Ultrasound

HOURS: Evenings

Jirok, George
MEDICAL SCHOOL: Univ of
 WI, 1981

RESIDENCIES: Brooke Army
 Med, San Antonio, 1982

Kaminski, Henry
MEDICAL SCHOOL: Univ of
 Illinois, 1983

INTERNSHIPS: Med Coll of
 WI

RESIDENCIES: Med Coll of WI

COVERAGE GROUP: Falls
 Medical Group

SERVICES: Circumcisions,
 Ultrasound, Venipuncture

HOURS: Evening

Kluger, Jack
MEDICAL SCHOOL: Marquette
 Univ, 1941

INTERNSHIPS: Med Coll of
 WI

RESIDENCIES: Milwaukee Co
 Hosp, 1946

Kohn, Michael Jr.
MEDICAL SCHOOL: Marquette
 Univ, 1958

INTERNSHIPS: St. Joseph's

HEALTH PAGES

Hosp, Milwaukee
RESIDENCIES: St. Joseph's
Hosp, Milwaukee
SERVICES: Circumcisions,
Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Lulich, Roger
MEDICAL SCHOOL: Oklahoma
State Univ, 1977
INTERNSHIPS: Northwest
Gen, Milwaukee
RESIDENCIES: St. Mary's Hosp
FELLOWSHIPS: Michael Reese
Hosp, Chicago
SERVICES: Ultrasound,
Venipuncture
CREDIT CARDS: MC & Visa

Lima, James
MEDICAL SCHOOL: Med Coll
of WI, 1980
INTERNSHIPS: Butterworth
Hosp, Michigan
RESIDENCIES: Butterworth
Hosp, Michigan, 1984
COVERAGE GROUP:
Northpoint
SERVICES: Circumcisions,
Ultrasound, Venipuncture
HOURS: Evenings &
Weekends

Lucca, Paul
MEDICAL SCHOOL: Med Coll
of WI, 1969
INTERNSHIPS: LAC/USC
Med Center, L.A.
RESIDENCIES: Milwaukee
County Gen Hosp
COVERAGE GROUP:
Milwaukee Medical Clinic
SERVICES: Ultrasound,
Venipuncture
HOURS: Weekends
CREDIT CARDS: MC, Visa, &
Amex

Majewski, Michael
MEDICAL SCHOOL:
Dartmouth Medical
School, 1978
INTERNSHIPS: Med Coll WI
RESIDENCIES: Univ of
Colorado
SERVICES:
Venipuncture
HOURS: Evening & Weekend

Maker, George
MEDICAL SCHOOL: Univ of
Vermont, 1976
INTERNSHIPS: Univ of WI,
1977
RESIDENCIES: Univ of WI,
1980

COVERAGE GROUP:
Burlington Clinic
SERVICES: Circumcisions,
Ultrasound, Venipuncture
HOURS: Weekend
CREDIT CARDS: MC & Visa

Mayer, Matthew
MEDICAL SCHOOL:
Georgetown Univ, 1971
INTERNSHIPS: Georgetown
Univ, 1972
RESIDENCIES: Georgetown
Univ, 1975
COVERAGE GROUP: Women's
Health Care
SERVICES: Circumcisions,
Ultrasound, Venipuncture
HOURS: Evenings &
Weekends
CREDIT CARDS: MC & Visa

Milman, Alfredo
MEDICAL SCHOOL: Far
Eastern Univ, Philippines,
1961
INTERNSHIPS: Mt. Sinai Med
Center, 1973
RESIDENCIES: Mt. Sinai Med
Center, 1976
SERVICES: Circumcisions,
Ultrasound

Miller, Donald Jr
MEDICAL SCHOOL: Kansas,
1976
RESIDENCIES: Henry Ford
Hosp, Detroit, 1980
COVERAGE GROUP: Racine
Medical Clinic
SERVICES: Ultrasound,
Venipuncture
CREDIT CARDS: MC & Visa

Musson, Jeffrey
MEDICAL SCHOOL: Michigan
State Univ, 1977
INTERNSHIPS:
Blodgett/St. Mary's Hosp
RESIDENCIES:
Blodgett/St. Mary's Hosp
COVERAGE GROUP: Racine
Medical Clinic
SERVICES: Circumcisions,
Ultrasound, Venipuncture
CREDIT CARDS: MC & Visa

Nash, David
MEDICAL SCHOOL: Univ of
WI, 1975
RESIDENCIES: Mt. Sinai Med
Center, Milwaukee
COVERAGE GROUP: Babitz
& Burstein
SERVICES: Circumcisions,
Ultrasound, Venipuncture

HOURS: Evenings
CREDIT CARDS: MC & Visa

Nohl, James
MEDICAL SCHOOL:
Universidad Autonoma de
Tamaulipas, 1982
INTERNSHIPS: Winthrop
Univ Hosp, Mineola, N.Y.
RESIDENCIES: Winthrop Univ
Hosp, Mineola, N.Y.
SERVICES: Circumcisions,
Ultrasound, Venipuncture
HOURS: Evening
CREDIT CARDS: MC & Visa

Pagedas, Anthony
MEDICAL SCHOOL: Indiana
Univ, 1963
INTERNSHIPS: Detroit
General Hosp, 1964
RESIDENCIES: Wayne State
Univ, 1968
SERVICES: Circumcisions,
Ultrasound, Venipuncture
HOURS: Evenings

Parker, Edward
MEDICAL SCHOOL: Marquette
Univ, 1964
INTERNSHIPS: St. Joseph's
Hosp, Milwaukee, 1965
RESIDENCIES: St. Joseph's
Hosp, Milwaukee, 1968
SERVICES: Circumcisions,
Ultrasound, Venipuncture

Patillo, Roland
MEDICAL SCHOOL: Univ of St.
Louis, 1959
INTERNSHIPS: Milwaukee Co
Gen Hosp, 1960
RESIDENCIES: Med Coll of
WI, 1964
FELLOWSHIPS: Johns
Hopkins Univ, 1967

Pollard, Philip
MEDICAL SCHOOL: Marquette
Univ, 1959
INTERNSHIPS: Milwaukee Co
Gen Hosp, 1960
RESIDENCIES: Johns Hopkins
Hosp, 1965

Pirson, Richard Adam
MEDICAL SCHOOL: Rush Med
Coll, 1983
INTERNSHIPS: Rush
Presbyterian-St. Lukes
Med Center
FELLOWSHIPS: Maternal-
Fetal Medicine
SERVICES: Circumcisions,
Ultrasound, Venipuncture

Poremski, Tod
MEDICAL SCHOOL: Loyola
Univ, 1975
INTERNSHIPS: Milwaukee Co.
Gen Hosp, 1977
RESIDENCIES: Milwaukee Co.
Gen Hosp, 1980
SERVICES: Ultrasound
HOURS: Evenings

Riendl, Anne
MEDICAL SCHOOL: Med Coll
WI, 1977
FELLOWSHIPS: Mt. Sinai Med
Center, Milwaukee, 1981

Shroeder, Thomas
MEDICAL SCHOOL: Univ of
Iowa, 1959
INTERNSHIPS: St. Joseph's
Hosp, Milwaukee, 1960
RESIDENCIES: St. Joseph's
Hosp, Milwaukee, 1965

Shafi, Mohammad
MEDICAL SCHOOL: Nishtar
Med Coll, Pakistan, 1964
RESIDENCIES: Mount Sinai
Hosp, Milwaukee
SERVICES: Midwives,
Circumcisions, Ultrasound
HOURS: Weekend

Sirin, Korim
MEDICAL SCHOOL: Ankara
Univ, Turkey, 1949
INTERNSHIPS: St. Barnabas
Hosp, Minneapolis, 1958
RESIDENCIES: Columbia
Hosp, Mt. Sinai Hosp,
1962
COVERAGE GROUP: Gahal,
Melnychenko & Sha'
SERVICES: Circumcisions,
Venipuncture

Stoff, Adolf
MEDICAL SCHOOL: Charles
Univ, Prague, Czech, 1957
INTERNSHIPS: Co Hosp
Cheb, Czech, 1958
RESIDENCIES: Charles Univ,
Czech, 1962

Stewart, William
MEDICAL SCHOOL: Marquette
Univ, 1962
INTERNSHIPS: St. Joseph's
Hosp, 1963
RESIDENCIES: St. Joseph's
Hosp, 1968
SERVICES: Ultrasound
HOURS: Evenings

HEALTH PAGES

Sturino, Kathy

MEDICAL SCHOOL: Med Coll of WI, 1983

INTERNSHIPS: Mt. Sinai Med Center, Milwaukee

RESIDENCIES: Mt. Sinai Med Center, Milwaukee, 1987

COVERAGE GROUP:

Womencare

SERVICES: Circumcisions, Ultrasound, Venipuncture

HOURS: Evenings

CREDIT CARDS: MC & Visa

Vitumvas, Gerald

MEDICAL SCHOOL: Nebraska, 1975

RESIDENCIES: Nebraska Affil Hosp, 1979

SERVICES: Ultrasound,

Venipuncture

HOURS: Weekend

CREDIT CARDS: MC & Visa

Warr, Robert

MEDICAL SCHOOL: Marquette Univ, 1968

INTERNSHIPS: St. Joseph's Hosp, Milwaukee, 1969

RESIDENCIES: St. Joseph's Hosp, Milwaukee, 1972

Washington, Janie Marie

MEDICAL SCHOOL: Univ of WI, 1982

INTERNSHIPS: Mt. Sinai Med Center, 1984

RESIDENCIES: Mt. Sinai Med Center, 1987

SERVICES: Circumcisions, Ultrasound, Venipuncture

CREDIT CARDS: MC, Visa & Amex

Wetzler, Robert

MEDICAL SCHOOL: Marquette Univ, 1968

INTERNSHIPS: St. Joseph's Hosp, 1969

COVERAGE GROUP: Medical Consultants, SC

SERVICES: Circumcisions,

Ultrasound, Venipuncture

HOURS: Evenings &

Weekends

CREDIT CARDS: MC & Visa

Worthington, Dennis

MEDICAL SCHOOL: Univ of Edinburgh-Scotland, 1966

INTERNSHIPS: Gen. Rose

Meml Hosp, Denver, 1967

RESIDENCIES: Queen's Univ,

Kingston, Canada, 1971

FELLOWSHIPS: Perinatal Med

Kingston Gen Hosp, 1972

SERVICES: Circumcisions, Ultrasound, Venipuncture

Yellick, Clyde

MEDICAL SCHOOL: Med Coll WI, 1956

INTERNSHIPS: St. Mary's

Hosp, Milwaukee, 1958

RESIDENCIES: St. Mary's

Hosp, Milwaukee, 1960

SERVICES: Ultrasound,

Venipuncture

HOURS: Evenings and

Weekends

FAMILY PRACTITIONERS

Lewan, Richard

MEDICAL SCHOOL: Univ of

Chicago, 1979

INTERNSHIPS: Univ of

Illinois-Rockford

RESIDENCIES: Univ of

Illinois-Rockford

SERVICES: Circumcisions,

Venipuncture

HOURS: Evenings

Ranola, Pedro

MEDICAL SCHOOL: Univ of Santo Tomas, 1967

INTERNSHIPS: St. Michael Hosp, Milwaukee, 1971

RESIDENCIES: St. Michael Hosp, Milwaukee, 1973

Stevens, Robert

MEDICAL SCHOOL: Med Coll of WI, 1984

RESIDENCIES: Med Coll of WI

SERVICES: Circumcisions, Venipuncture

ENT (OTOLARYNGOLOGISTS)

RESEARCH

Mills, John M

MEDICAL SCHOOL: Univ of Illinois, 1959

INTERNSHIPS: Letterman

Hosp, San Francisco, 1960

RESIDENCIES: Univ of

Illinois, 1967

TEACHING POSITION

Assistant Professor, Univ

of WI

CREDIT CARDS: MC & Visa

Schmidt, Frederic

MEDICAL SCHOOL: Med Coll of WI, 1983

RESIDENCIES: Med Coll of WI, 1988

Titoloer, Richard

MEDICAL SCHOOL: Univ of WI, 1967

INTERNSHIPS: St. Mary's

Hosp, Duluth, 1968

RESIDENCIES: Med Coll of

WI, 1975

Vander, Woode

MEDICAL SCHOOL: Univ of Michigan, 1966

INTERNSHIPS: Blodgett

Meml Hosp, Grand

Rapids, 1967

RESIDENCIES: Univ of

Michigan, 1972

Wineinger, David

MEDICAL SCHOOL: Univ of Michigan

INTERNSHIPS: Illinois

Research & Ed Hosp,

1963

RESIDENCIES: Univ of

Illinois, 1967

ENT

Donovan, Timothy J

MEDICAL SCHOOL: Univ of WI, 1964

INTERNSHIPS: Wayne Co Gen Hosp, Michigan, 1965

Finch, William Wesley

MEDICAL SCHOOL: Univ of WI, 1973

INTERNSHIPS: Kaiser Hosp

Oakland Cal, 1974

RESIDENCIES: Univ of WI,

1978

CREDIT CARDS: MC & Visa

Ford, Charles M

MEDICAL SCHOOL: Univ of Louisville, 1965

INTERNSHIPS: Henry Ford

Hosp, Detroit, 1966

RESIDENCIES: Henry Ford

Hosp, Detroit, 1970

TEACHING POSITION: Prof,

Univ of WI

SERVICES: Venipuncture

CREDIT CARDS: MC & Visa

Scott, John Kimball

MEDICAL SCHOOL: Ohio State Univ, 1954

INTERNSHIPS: White Cross

Hosp

RESIDENCIES: Ohio State

Univ, 1958

CREDIT CARDS: MC & Visa

Stanley, Robert John

MEDICAL SCHOOL: Univ of WI, 1977

RESIDENCIES: Guthrie Clinic,

Sayre, PA, 1983

FELLOWSHIPS: Mayo Clinic,

1988

ENT

Barton, James Robert

MEDICAL SCHOOL: West Virginia Univ, 1971

INTERNSHIPS: Roanoke

Hosp, 1972

RESIDENCIES: Med Coll of

WI, 1980

CREDIT CARDS: MC & Visa

Belson, Thomas Patrick

MEDICAL SCHOOL: Marquette Univ, 1963

INTERNSHIPS: St Francis

Hosp, Illinois, 1964

RESIDENCIES: VA Center,

Wood, 1970

TEACHING POSITION:

Associate Clinical

Professor, Med Coll of WI

Condon, Kenneth Gerard

MEDICAL SCHOOL: Univ of WI, 1980

INTERNSHIPS: Charity Hosp,

New Orleans, 1981

RESIDENCIES: Univ of WI,

1987

CREDIT CARDS: MC & Visa

Dankle, Steven Kie

MEDICAL SCHOOL: Univ of Iowa, 1982

RESIDENCIES: Ohio State

Univ, 1987

CREDIT CARDS: MC & Visa

HEALTH PAGES

Darling, William Anthony

MEDICAL SCHOOL: Med Coll of WI, 1969
 INTERNSHIPS: St. Joseph Hosp., Denver, 1970
 RESIDENCIES: Med Coll of WI, 1974
 TEACHING POSITION: Associate Clinical Professor, Med Coll of WI

Durkin, Gretchen Elizabeth

MEDICAL SCHOOL: Indiana Univ, 1981
 INTERNSHIPS: Med Coll of WI
 RESIDENCIES: Med Coll of WI
 HOURS: Evening

Friedman, Jerry Eli

MEDICAL SCHOOL: Univ of Illinois, 1961
 INTERNSHIPS: L. A. Co Gen Hosp, 1962
 RESIDENCIES: VA Hosp, Ill., 1963; Ill Research & Educ Hosp, 1966
 TEACHING POSITION: Professor, Med Coll of WI

Grunka, Richard John

MEDICAL SCHOOL: Med Coll of WI, 1977
 INTERNSHIPS: St. Luke's Hosp., Milw, 1978
 RESIDENCIES: Med Coll of WI, 1982
 TEACHING POSITION: Assistant Clinical Professor, Med Coll of WI
SERVICES: Venipuncture
 CREDIT CARDS: MC & Visa

Jamowitz, Michael Charles

MEDICAL SCHOOL: Loyola Univ, 1972
 INTERNSHIPS: Josephs Hosp., Milw, 1973
 RESIDENCIES: Med Coll of WI, 1977
 TEACHING POSITION: Med Coll of WI

Kludor, Thomas

MEDICAL SCHOOL: Med Coll of WI, 1968
 INTERNSHIPS: Columbia Hosp., Milw, 1969
 RESIDENCIES: Med Coll of WI, 1973
 TEACHING POSITION: Assistant Professor, Med Coll of WI

Kleiner, Harvey

MEDICAL SCHOOL: Med Coll of WI, 1972
 INTERNSHIPS: Cedars Sinai Hosp., L.A.
 RESIDENCIES: Med Coll of WI
 TEACHING POSITION: Med Coll of WI

Martinelli, Dean Louis

MEDICAL SCHOOL: Loyola Stritch Med School, 1971
 INTERNSHIPS: Milwaukee County
 RESIDENCIES: Milwaukee County Institute
 TEACHING POSITION: Med Coll of WI

Park, John Raymond

MEDICAL SCHOOL: George Washington Univ, 1968
 INTERNSHIPS: Cleveland Metro Hosp, 1969
 RESIDENCIES: Univ of Minnesota, 1974
 TEACHING POSITION: Med Coll of WI
 CREDIT CARDS: MC & Visa

Warner, Douglas John

MEDICAL SCHOOL: Med Coll of WI, 1984
 RESIDENCIES: Duke Univ, 1989
 TEACHING POSITION: Clinical Instructor, Med Coll of WI
SERVICES: Venipuncture

ONCOLOGISTS

Bayer, Gerald

MEDICAL SCHOOL: Univ of WI, 1974
 INTERNSHIPS: Akron Genl Med Ctr, 1975
 RESIDENCIES: Akron Genl Med Ctr, 1977
 FELLOWSHIPS: Univ Hosps., Cleveland, 1979

Blank, Jules

MEDICAL SCHOOL: Loyola Univ, 1978
 INTERNSHIPS: Southern Ill Univ, 1978
 RESIDENCIES: Southern Ill Univ, 1981
 FELLOWSHIPS: Univ of Conn., Farmington, 1984

Koch, Paul

MEDICAL SCHOOL: Indiana Univ, 1968
 INTERNSHIPS: Hurley Hosp., Flint, 1969
 RESIDENCIES: SUNY, Buffalo, 1974
 FELLOWSHIPS: Brown Univ, 1976

Carbone, Paul

MEDICAL SCHOOL: Albany Med Coll, 1956
 INTERNSHIPS: USPHS Hosp., Baltimore, 1957
 RESIDENCIES: USPHS Hosp., San Francisco, 1960; National Institute of Health, 1963
 TEACHING POSITION: Professor Human Oncology, Univ of WI
SERVICES: Venipuncture
 CREDIT CARDS: MC/Visa

Diggs, Charles

MEDICAL SCHOOL: Johns Hopkins Univ, 1972
 INTERNSHIPS: Johns Hopkins Hosp, 1973
 RESIDENCIES: Johns Hopkins Hosp, 1974
 FELLOWSHIPS: Baltimore Cancer Research Ctr, 1977
SERVICES: Venipuncture

Ersbiler, William

MEDICAL SCHOOL: State Univ NY, 1974
 INTERNSHIPS: Univ of WI, 1975
 RESIDENCIES: Univ of WI, Madison, 1977
 FELLOWSHIPS: Univ of WI, Madison, 1980
 TEACHING POSITION: Professor, Univ of WI
SERVICES: Venipuncture
 HOURS: Evenings & Weekends
 CREDIT CARDS: MC/Visa

Kolder, Peter

MEDICAL SCHOOL: George Washington Univ, 1979
 INTERNSHIPS: Univ of WI, 1980
 RESIDENCIES: Univ of WI, 1982
 FELLOWSHIPS: Univ of WI, 1985

Longo, Walter

MEDICAL SCHOOL: Univ of Nebraska, 1977
 INTERNSHIPS: Mayo Clinic
 RESIDENCIES: Mayo Clinic
 FELLOWSHIPS: Univ of WI
 TEACHING POSITION: Assoc Professor, Univ of WI
SERVICES: Venipuncture
 CREDIT CARDS: MC, Visa & Amex

Prendergast, Edward

MEDICAL SCHOOL: Univ of Chicago, 1973
 INTERNSHIPS: Univ of WI, 1974
 RESIDENCIES: Univ of WI, 1976
 FELLOWSHIPS: Montefiore Hosp., N. Y., 1978

Robins, Henry

MEDICAL SCHOOL: Boston Univ, 1976
 INTERNSHIPS: U Wisc Hosp., Madison, 1977
 RESIDENCIES: U Wisc Hosp., Madison, 1981
 FELLOWSHIPS: U Wisc Hosp., Madison, 1981
 TEACHING POSITION: Professor Human Oncology, Univ of WI
SERVICES: Venipuncture
 CREDIT CARDS: MC/Visa

HEALTH PAGES

MILWAUKEE

Anderson, Tom

MEDICAL SCHOOL: Stanford Univ, 1969
INTERNSHIPS: Strong Meml Hosp, Rochester, 1970
RESIDENCIES: Strong Meml Hosp, Rochester, 1975
FELLOWSHIPS: NCI/Strong Meml Hosp, 1974

Bomzer, Charles

MEDICAL SCHOOL: Northwestern Univ, 1978
INTERNSHIPS: Univ Minn Hosps, 1979
RESIDENCIES: Univ Minn Hosps, 1981
FELLOWSHIPS: Univ of Rochester, 1986

Borden, Ernest

MEDICAL SCHOOL: Duke Univ, 1966
INTERNSHIPS: Duke Hosp, 1967
RESIDENCIES: Univ of Pennsylvania, 1968
FELLOWSHIPS: John Hopkins Univ, 1973

Chitambar, Christopher

MEDICAL SCHOOL: Punjab Univ, India, 1977
INTERNSHIPS: Brackenridge Hosp, Texas, 1978
RESIDENCIES: Brackenridge Hosp, Texas, 1980
FELLOWSHIPS: Univ of Colorado, 1983
TEACHING POSITION: Associate Professor, Med Coll of WI
SERVICES: Venipuncture

Divgi, Ajit

MEDICAL SCHOOL: Univ of Bombay, 1973
INTERNSHIPS: Bergen Pines Co Hosp, N.J., 1975
RESIDENCIES: Bronx VA-Mt Sinai, Milwaukee, 1976
FELLOWSHIPS: Bronx VA-Mt Sinai, Milwaukee, 1978
TEACHING POSITION: Assistant Professor, Med Coll of WI
SERVICES: Venipuncture

Dubeer, Howard

MEDICAL SCHOOL: Univ of Illinois, 1969
INTERNSHIPS: Univ of Cincinnati, 1970

RESIDENCIES: Univ of Cincinnati, 1972
FELLOWSHIPS: Univ of WI, 1974

Geimer, Nicholas

MEDICAL SCHOOL: Univ of WI, 1963
INTERNSHIPS: UCLA, 1964
RESIDENCIES: Milwaukee Co Genl Hosp, 1969
FELLOWSHIPS: Milwaukee Co Genl Hosp, 1970
TEACHING POSITION: Associate Professor, Med Coll of WI
SERVICES: Venipuncture

Kallas, Gerald

MEDICAL SCHOOL: Marquette Univ, 1962
INTERNSHIPS: Milwaukee Co Genl Hosp, 1963
RESIDENCIES: Milwaukee Co Genl Hosp, 1967
FELLOWSHIPS: Milwaukee Co Genl Hosp, 1969
SERVICES: Venipuncture

Oesterling, Kurt

MEDICAL SCHOOL: Cornell Univ, 1977
INTERNSHIPS: Med Coll WI, 1978
RESIDENCIES: Med Coll WI, 1980
FELLOWSHIPS: Univ of Rochester, 1982

Ritch, Paul

MEDICAL SCHOOL: Tufts Univ, 1973
INTERNSHIPS: Barnes Hosp, St Louis, 1974
RESIDENCIES: Anderson Hosp, Houston, 1977
FELLOWSHIPS: National Cancer Institute, 1980

Taylor, Robert

MEDICAL SCHOOL: Yale Univ, 1973
INTERNSHIPS: Univ of Minnesota Hosp, 1975
RESIDENCIES: Univ of Minnesota Hosp, 1978
FELLOWSHIPS: Univ of Washington, 1980
SERVICES: Venipuncture

Vukelich, Majorie

MEDICAL SCHOOL: Univ of Minnesota, 1981
INTERNSHIPS: Dartmouth Univ, 1982
RESIDENCIES: Dartmouth Univ, 1984

FELLOWSHIPS: Med Coll of WI, 1987

Weissman, David

MEDICAL SCHOOL: Univ of San Diego, 1980
INTERNSHIPS: Univ of San Diego, 1981
RESIDENCIES: Univ of San Diego, 1983
FELLOWSHIPS: Johns Hopkins Univ, 1985

SURGEONS

GREEN BAY

Anderas, Per

MEDICAL SCHOOL: Northwestern Univ, 1981
INTERNSHIPS: Milwaukee County Hospital, 1983
RESIDENCIES: St Joseph's Hosp, Milw, 1986

Bernacki, Michael

MEDICAL SCHOOL: Loyola Univ, 1982
INTERNSHIPS: Univ of Illinois, 1987
RESIDENCIES: Univ of Illinois, 1987
SERVICES: Venipuncture
HOURS: Evenings
CREDIT CARDS: Yes

Geocaris, Thomas

MEDICAL SCHOOL: Loyola Univ, 1968
INTERNSHIPS: Chicago Wesley Meml Hosp, 1969
RESIDENCIES: Univ of Illinois, 1974

Manke, David

MEDICAL SCHOOL: Univ of Cincinnati, 1972
INTERNSHIPS: Hennepin County Hosp, 1975
RESIDENCIES: Iowa Methodist Med Ctr, 1978
FELLOWSHIPS: Univ of Southern Illinois, 1980
SERVICES: Venipuncture
CREDIT CARDS: MC/Visa

Reckard, Paul

MEDICAL SCHOOL: Univ of Minnesota, 1984
INTERNSHIPS: Hennepin County Hosp, 1985
RESIDENCIES: VA Med Ctr, Des Moines, 1990
SERVICES: Venipuncture

CREDIT CARDS: MC/Visa

MADISON

Mockman, Sanford

MEDICAL SCHOOL: Univ of WI, 1959
INTERNSHIPS: Univ of Minnesota, 1960
RESIDENCIES: Univ of WI, 1964

Wenger, Ronald

MEDICAL SCHOOL: Case Western Univ, 1970
INTERNSHIPS: Oregon Hosps, 1971
RESIDENCIES: Mayo Clinic, 1977

Wolberg, William

MEDICAL SCHOOL: Univ of WI, 1956
INTERNSHIPS: Ohio State Univ, 1957
RESIDENCIES: Univ of WI, 1961
TEACHING POSITION: Prof Surgery and Human Oncology, Univ of WI
SERVICES: Venipuncture
CREDIT CARDS: MC/Visa

MILWAUKEE

Altman, David

MEDICAL SCHOOL: Univ of WI, 1961
INTERNSHIPS: Mt Sinai Hosp, 1962
RESIDENCIES: Marquette Univ, 1966
TEACHING POSITION: Clinical Assistant Professor, Med Coll of WI
SERVICES: Venipuncture

Battista, Joseph

MEDICAL SCHOOL: Northwestern Univ, 1983
INTERNSHIPS: Med Coll of WI, 1985
RESIDENCIES: Med Coll of WI, 1987
SERVICES: Venipuncture

Bowman, John

MEDICAL SCHOOL: Univ of Cincinnati, 1966
INTERNSHIPS: Univ of Cincinnati, 1967
RESIDENCIES: Marquette Affil, 1971
TEACHING POSITION: Associate Professor, Med Coll of WI

HEALTH PAGES

SERVICES: Venipuncture**Davies, William**

MEDICAL SCHOOL: Univ of WI, 1965
 INTERNSHIPS: Boston City Hosp, 1966
 RESIDENCIES: Marquette Affiliated Hosps, 1970
 TEACHING POSITION: Assistant Clinical Professor, Med Coll of WI

Elkhem, Gregory

MEDICAL SCHOOL: Univ of Minnesota, 1973
 INTERNSHIPS: Med Coll of WI
 RESIDENCIES: Med Coll of WI
 TEACHING POSITION: Assistant Professor, Med Coll of WI
 CREDIT CARDS: MC/Visa

Farrell, David

MEDICAL SCHOOL: Med Coll of WI, 1979
 INTERNSHIPS: St. Luke's Hosp, Milw
 RESIDENCIES: St. Luke's Hosp, Milw, 1984

Flynn, George

MEDICAL SCHOOL: Marquette Univ, 1956
 INTERNSHIPS: Milw Co Hosp, 1957
 RESIDENCIES: VA Center Wood WI, 1961

Fox, Paul

MEDICAL SCHOOL: Marquette Univ, 1968
 INTERNSHIPS: Univ of Chicago Hospital & Clinics
 RESIDENCIES: Med Coll of WI
 TEACHING POSITION: Assistant Clinical Professor, Med Coll of WI

Grieshop, Joseph

MEDICAL SCHOOL: Marquette Univ, 1965
 INTERNSHIPS: Milw Co Gen Hosp, 1966
 RESIDENCIES: Marquette Affil, 1970
SERVICES: Venipuncture

Hardacre II, Jerry

MEDICAL SCHOOL: Univ of WI, 1985
 INTERNSHIPS: Indiana Univ

RESIDENCIES: Indiana Univ

SERVICES: Venipuncture

HOURS: Weekend
 CREDIT CARDS: MC/Visa

Jan, Mazhar

MEDICAL SCHOOL: King Edward Med Sch (Lahore), 1963
 INTERNSHIPS: Columbus Hosp, Chicago, 1965
 RESIDENCIES: Mt. Sinai Hosp, Milw, 1971

Kappes, Steven

MEDICAL SCHOOL: Indiana Univ, 1977
 RESIDENCIES: Med Coll of WI, 1982

Kelley, William

MEDICAL SCHOOL: St. Louis Univ, 1967
 INTERNSHIPS: Univ of Rochester
 RESIDENCIES: St. Joseph's Hosp, Milwaukee, 1972
 TEACHING POSITION: Assistant Clinical Professor, Med Coll of WI
SERVICES: Venipuncture
 HOURS: Weekends

Kispart, John

MEDICAL SCHOOL: Wayne State Univ, 1984
 INTERNSHIPS: Med Coll of WI
 RESIDENCIES: Med Coll of WI
 FELLOWSHIPS: Univ of Kentucky
SERVICES: Venipuncture

Mikhalson, Wendy

MEDICAL SCHOOL: Med Coll WI, 1980

Mittel, Ram

MEDICAL SCHOOL: Med Coll Amritsar, India, 1970
 INTERNSHIPS: Hutzel Hosp, Detroit, 1973
 RESIDENCIES: Sinai Hosp, Detroit & Milw, 1977
SERVICES: Venipuncture
 HOURS: Evenings & Weekends

Pogner, Archibald

MEDICAL SCHOOL: Univ of Michigan, 1981
 RESIDENCIES: Milwaukee County Medical Complex, 1986
 TEACHING POSITION:

Assistant Clinical Professor, Med Coll of WI

Sattler, Marvin

MEDICAL SCHOOL: Marquette Univ, 1946
 INTERNSHIPS: Mt. Sinai Hospital
 RESIDENCIES: Mt. Sinai Hospital
 TEACHING POSITION: Associate Clinical Professor, Med Coll of WI

Schmidt, Robert

MEDICAL SCHOOL: Cornell Univ, 1966
 INTERNSHIPS: U Hosps of Cleve, 1965
 RESIDENCIES: U Hosps of Cleve, 1972

Schmitt, David

MEDICAL SCHOOL: Med Coll of WI, 1982
 RESIDENCIES: Med Coll of WI, 1987
 FELLOWSHIPS: Med Coll of WI, 1989
 TEACHING POSITION: Assistant Professor, Med Coll of WI

Slaight, Douglas

MEDICAL SCHOOL: Ohio State Univ, 1969
 INTERNSHIPS: Univ of Illinois, 1970
 RESIDENCIES: Univ of Illinois, 1975
 TEACHING POSITION: Med Coll of WI
SERVICES: Venipuncture
 HOURS: Weekends

Stobbs, Kneel

MEDICAL SCHOOL: Univ of Louisville, 1959
 INTERNSHIPS: Norton Meml Hosp, Louisville, 1957
 RESIDENCIES: Mayo Clinic, 1965
 HOURS: Evening

Tiffany II, Joseph

MEDICAL SCHOOL: Northwestern Univ, 1965
 INTERNSHIPS: Cook Co Hosp, Chicago, 1966
 RESIDENCIES: Allegheny Gen Hosp, Pitt, 1971
 FELLOWSHIPS: Mayo Clinic, Minnesota, 1968

Tinn, Mark

MEDICAL SCHOOL: Univ of

North Dakota, 1987
 INTERNSHIPS: Med Coll of WI

RESIDENCIES: Med Coll of WI

SERVICES: Venipuncture
 HOURS: Evenings & Weekends

Vincent, Dennis

MEDICAL SCHOOL: Med Coll of WI, 1982
 INTERNSHIPS: Univ of Kentucky
 RESIDENCIES: Univ of Kentucky
 FELLOWSHIPS: Ochsner Medical Foundation
 TEACHING POSITION: Assistant Professor, Med Coll of WI
 CREDIT CARDS: MC/Visa

Wilson, Donald

MEDICAL SCHOOL: Marquette Univ, 1969
 INTERNSHIPS: St. Joseph Hosp, Denver, 1970
 RESIDENCIES: Mayo Clinic, Minnesota, 1975
 TEACHING POSITION: Assistant Clinical Professor, Med Coll of WI

Woods, James

MEDICAL SCHOOL: Indiana Univ, 1968
 INTERNSHIPS: Med Coll of WI, 1969
 RESIDENCIES: Med Coll of WI, 1975
 TEACHING POSITION: Associate Clinical Professor, Med Coll of WI
 CREDIT CARDS: MC/Visa

HEALTH PAGES

UROLOGISTS

GREEN BAY

Kennedy, Timothy

MEDICAL SCHOOL: Univ of Iowa
 INTERNSHIPS: Parkland Hosp., Univ of Texas
 RESIDENCIES: Parkland Hospital, 1989
 SERVICES: Venipuncture

Mariotti, Myron Max

MEDICAL SCHOOL: Univ of Illinois, 1971
 INTERNSHIPS: Univ of Illinois, 1972
 RESIDENCIES: Univ of Illinois, 1976
 SERVICES: Venipuncture

Schiebler, John Charles

MEDICAL SCHOOL: Cornell Univ, 1961
 RESIDENCIES: St Francis Hosp., La Crosse, 1970
 SERVICES: Venipuncture

Someland, Arthur Malcolm III

MEDICAL SCHOOL: Univ of WI, 1978
 INTERNSHIPS: Univ of WI
 RESIDENCIES: Univ of WI, 1983
 SERVICES: Venipuncture

Troup, Charles W.

MEDICAL SCHOOL: Northwestern Univ, 1963
 INTERNSHIPS: Wesley Hosp., Chicago, 1964
 RESIDENCIES: Med Coll WI, 1971
 SERVICES: Venipuncture

MADISON

Bruskewitz, Reginald C

MEDICAL SCHOOL: Univ of WI, 1973
 INTERNSHIPS: Univ of WI, 1974
 RESIDENCIES: Univ of WI, 1978

Graf, Richard Andrew

MEDICAL SCHOOL: Univ of WI, 1956
 INTERNSHIPS: Univ of Texas, 1956
 RESIDENCIES: Univ of Iowa, 1964
 CREDIT CARDS: MC & Visa

Greenberg, Earl Barry

MEDICAL SCHOOL: Univ of Miami, 1963
 INTERNSHIPS: L.A. County Hosp., 1964
 RESIDENCIES: US Naval Hosp USS Repose, 1970

Kuglitsch, Michael Ervin

MEDICAL SCHOOL: Loyola Stritch, 1980
 RESIDENCIES: Univ of WI, 1985
 CREDIT CARDS: MC & Visa

Licklider, Gary Melvin

MEDICAL SCHOOL: Univ of WI, 1971
 INTERNSHIPS: San Francisco Hosp., 1972
 RESIDENCIES: Univ of California, 1977

Mahler, John Herbert

MEDICAL SCHOOL: Univ of Minn, 1963
 INTERNSHIPS: VA Hosp & Minn Hosp, 1971
 CREDIT CARDS: MC & Visa

Malek, Ghoham H.

MEDICAL SCHOOL: Univ of Tabriz (Iran), 1961
 INTERNSHIPS: Providence Hosp Wash., 1965
 RESIDENCIES: Univ WI, 1969
 CREDIT CARDS: MC & Visa

Messing, Edward M.

MEDICAL SCHOOL: Univ of Tabriz (Iran), 1961
 INTERNSHIPS: Providence Hosp Washington, 1965
 RESIDENCIES: Stanford Univ, 1978

Moon, Timothy David

MEDICAL SCHOOL: Univ of Edinburgh (Scotland), 1972
 RESIDENCIES: Queen's Univ, Canada, 1980

Smith, Franklin Leo

MEDICAL SCHOOL: Northwestern Univ, 1982
 RESIDENCIES: Surgery, Northwestern Univ, 1984
 Urol; Univ of Chicago, 1987

Uehling, David T

MEDICAL SCHOOL: Northwestern Univ, 1959
 INTERNSHIPS: Cook Co Hosp., Chicago, 1960

RESIDENCIES: Northwestern Univ, Chicago, 1964

Waters, Raul F

MEDICAL SCHOOL: Wayne Univ, 1961
 INTERNSHIPS: Grace Hosp., Detroit, 1963
 RESIDENCIES: Marquette Univ, 1966

Wegenke, John D.

MEDICAL SCHOOL: Univ of WI
 INTERNSHIPS: San Joaquin Genl, Stockton, 1972
 RESIDENCIES: Marquette Univ, 1976
 CREDIT CARDS: MC & Visa

MILWAUKEE

Andres, Francis I.

MEDICAL SCHOOL: Marquette Univ, 1958
 INTERNSHIPS: St Joseph Hosp., Milwaukee, 1959
 RESIDENCIES: St Joseph Hosp., Milwaukee, 1963
 and Med Coll WI, 1966

Annesley, William H., Jr.

MEDICAL SCHOOL: Med Coll WI, 1977
 INTERNSHIPS: Med Coll WI, 1978
 RESIDENCIES: Med Coll WI, 1982

Bogum, Frank Phillip

MEDICAL SCHOOL: Univ of Michigan, 1979
 INTERNSHIPS: Univ of Michigan, Affil Hosp., 1981
 RESIDENCIES: Univ of Michigan, Affil Hosp., 1984
 SERVICES: Venipuncture
 CREDIT CARDS: Visa & MC

Bourne, Charles W.

MEDICAL SCHOOL: Univ of Michigan, 1959
 INTERNSHIPS: Univ of Michigan, 1960
 RESIDENCIES: Univ of Michigan, 1965

Bourne, Richard B.

MEDICAL SCHOOL: Univ of Michigan, 1958
 INTERNSHIPS: Univ of Michigan, 1959
 RESIDENCIES: Univ of Michigan, Affil Hosp.,

1964

SERVICES: Venipuncture
 HOURS: Weekend

Dixon, Christopher

MEDICAL SCHOOL: Med Coll of WI
 RESIDENCIES: Wayne State Univ, Detroit
 FELLOWSHIPS: Univ of CA - San Francisco
 TEACHING POSITION: Assistant Professor, Med Coll of WI
 SERVICES: Venipuncture
 CREDIT CARDS: MC & Visa

Ferber, Thomas

MEDICAL SCHOOL: Univ of WI, 1976
 INTERNSHIPS: Univ of WI Affil Hosps, Madison, 1977
 RESIDENCIES: Univ of WI Affil Hosps, Madison, 1981

Fine, Stuart W.

MEDICAL SCHOOL: Univ of Louisville, 1963
 INTERNSHIPS: Mount Sinai, Milwaukee
 RESIDENCIES: Marquette Univ

Flanagan, W. Patrick, Jr.

MEDICAL SCHOOL: LSU Sch Med, New Orleans, 1980
 INTERNSHIPS: Shands Hosp., Gainesville, 1981
 RESIDENCIES: Ochsner Foundation Hosp, New Orleans, 1988

Harkavy, Raymond

MEDICAL SCHOOL: Univ of WI, 1953
 INTERNSHIPS: St. Joseph's Hosp., Milwaukee, 1954
 RESIDENCIES: St. Joseph's Hosp., Milwaukee, 1957

Hein, Richard C.

MEDICAL SCHOOL: Northwestern Univ, 1986
 INTERNSHIPS: Passavant Meml Hosp., Chicago, 1967
 RESIDENCIES: Northwestern Univ, Chicago, 1974

Herrman, Richard A.

MEDICAL SCHOOL: Univ of WI Med Sch, 1966
 INTERNSHIPS: Milwaukee County Hosp, 1967

HEALTH PAGES

RESIDENCIES: Med Coll WI, 1973

Hodgson, Norman B.

MEDICAL SCHOOL: Univ of Michigan, 1951
INTERNSHIPS: Univ of Michigan, 1952
RESIDENCIES: Univ of Michigan, 1956
SERVICES: Venipuncture
HOURS: Weekend

Jacobson, Harold A.

MEDICAL SCHOOL: Med Coll WI

Kearns, John Westhofen

MEDICAL SCHOOL: John Hopkins Univ, 1947
INTERNSHIPS: St Luke's Hosp, Chicago, 1948
RESIDENCIES: John Hopkins, 1949; Wesley Meml Hosp, Chicago, 1951

Lawson, Russell K.

MEDICAL SCHOOL: Univ of Oregon, 1963
INTERNSHIPS: L.A. County Hosp, 1964
RESIDENCIES: Univ of Oregon, 1968
TEACHING POSITION: Chairman, Dept of Urology, Med Coll WI
SERVICES: Venipuncture
HOURS: Evenings & Weekends

Lepor, Herbert

MEDICAL SCHOOL: Johns Hopkins Univ, 1979
INTERNSHIPS: Johns Hopkins Hosp, 1980
RESIDENCIES: Johns Hopkins Hosp, 1986
TEACHING POSITION: Professor Med Coll Wisc and Director, Med Coll Wisc Prostate Center
SERVICES: Venipuncture
CREDIT CARDS: MC & Visa

McGills, Alexander J.

MEDICAL SCHOOL: Med Coll Wisc, 1956
INTERNSHIPS: Univ of Iowa Hosp
RESIDENCIES: Surgery, St Joseph Hosp, 1961; Rochester Med Ctr, 1965
TEACHING POSITION: Assistant Clinical Professor, Med Coll WI

Manuel, Emmanuel S.

MEDICAL SCHOOL: Univ Santo Tomas, Manila, 1971
INTERNSHIPS: Evangelical Deaconess Hosp, Milwaukee, 1973
RESIDENCIES: Surg. Mt. Sinai Hosp, N.Y., 1976; Urol, LI Jewish, N.Y., 1980

Otto, Samuel J.

MEDICAL SCHOOL: Univ of WI, 1971
INTERNSHIPS: York Hosp, PA, 1972
RESIDENCIES: Med Coll WI, 1978

Pollard, Randle E.

MEDICAL SCHOOL: Meharry, 1951
INTERNSHIPS: Fordham Hosp, N.Y., 1952
RESIDENCIES: Med Coll WI, 1958
TEACHING POSITION: Professor, Med Coll WI
HOURS: Evenings

Pope, John Francis

MEDICAL SCHOOL: St. Georges Univ, Grenada, 1981
RESIDENCIES: Surgery, St Josephs Hosp, Milw, 1981; Urol, Butterworth Hosp, Mich, 1986

Resmussen, Robert James

MEDICAL SCHOOL: Univ of Wisconsin, 1957
RESIDENCIES: Milwaukee County Hosp, 1962

Silber, John David

MEDICAL SCHOOL: Marquette Univ, 1947
INTERNSHIPS: Albert Einstein, PA, 1948
RESIDENCIES: Affil Hosp, Univ of WI, 1954
TEACHING POSITION: Professor, Med Coll WI

Slocum, Peter

MEDICAL SCHOOL: Univ of WI, 1983
INTERNSHIPS: Rush Presb-St.

Lukes, Chicago
RESIDENCIES: Rush Presb-St. Lukes, Chicago

Usow, Barry H.

MEDICAL SCHOOL: Univ of WI

Walsh, John Patrick

MEDICAL SCHOOL: Marquette University, 1967
INTERNSHIPS: Chelsea Naval Hosp Boston, 1968
RESIDENCIES: Medical County General Hospital, 1976
TEACHING POSITION: Assistant Clinical Professor, Med Coll WI
SERVICES: Venipuncture
HOURS: Weekends

Weisenthal, Charles Leonard

MEDICAL SCHOOL: Chicago Med Sch, 1955
INTERNSHIPS: Milwaukee County Hosp, 1956
RESIDENCIES: VA Hosp, 1960

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SPECIAL REPORTS

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Subcommittee on Regulation, Business Opportunities,
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Informed Consent: The Role Of Consumer Choice
In Improving The Quality Of Health Care

Monday, June 28, 1993

Testimony of
Edward Hannan, Ph.D.
Consultant to the New York State Health Department
Albany, N.Y.

For more than two decades, The New York State Department of Health has convened a Cardiac Advisory Committee, which consists primarily of practicing cardiac surgeons and cardiologists from New York as well as physicians and researchers from other states. The Committee is responsible for investigating issues related to quality assurance, appropriateness of surgery, and prevention and control of cardiovascular disease. In 1988, the Department and the Committee developed a form for collecting clinical data for all patients undergoing open heart surgery after January 1, 1989. The cardiac surgery departments in all 30 hospitals performing cardiac surgery in New York collect the data, code it on a personal computer, and then submit it to the Department of Health.

The major purposes of this data registry are to (1) provide information to hospitals that would aid them in assessing and improving their quality of care, and in determining when cardiac surgery is appropriate, (2) assist the New York State Department of Health in its quality assurance activities, and (3) to provide consumers with information that would aid them in selecting providers of cardiac surgery.

Focusing on coronary artery bypass graft surgery, which comprises about 75% of all cardiac surgery, the Department of Health has used information from the registry to develop a statistical model that determines which pre-operative risk factors in the data system are significantly related to in-hospital death and complications, and predicts the probability of

these adverse outcomes given the presence of various risk factors. The statistical model is also used to assess provider outcomes by obtaining a predicted mortality rate for each provider and comparing it to the provider's actual mortality rate.

Data from the system form the foundation upon which many quality improvement activities are based. Hospitals at which bypass surgery is performed receive data on a regular basis that report their actual and risk-adjusted mortality rates. Examinations of these data have led individual institutions to make specific changes in their cardiac surgery programs. Furthermore, the Department of Health provides each hospital with a personal computer diskette which contains a list of the pre-operative risk factors for CABG surgery that are significantly related to inpatient mortality. Users check which of the risk factors are present in a given patient, and are then provided with the predicted probability of in-hospital mortality for the CABG surgery patient on the basis of New York State experience. Another diskette provides each hospital with surgeon-specific information on the number of CABG operations, number of deaths, crude mortality rate, and risk-adjusted mortality rate for a specified time interval.

Guided by the Cardiac Advisory Committee, the Department of Health also uses these data to assist specific quality improvement interventions in hospitals with the highest risk-adjusted mortality rates. These interventions have included site

visits, comprehensive consultations, and placing some programs on a period of probation until recommended changes are instituted to improve quality of care.

With regard to consumer information for CABG surgery, NYSDOH has publicly released information by hospital on volumes of cases, actual mortality rates, and risk-adjusted mortality rates as well as identifying which hospitals have significantly higher and lower mortality rates than expected. Hospital - specific results have been released since 1990, and surgeon - specific results since 1991. In 1992, the Department released surgeon risk-adjusted CABG mortality rates for the three year period 1989-1991 for surgeons who had performed at least 200 isolated CABG operations in the time period.

We believe that this quality improvement program, based on the collection and dissemination of risk-adjusted mortality data for CABG surgery, played a significant role in improving the performance of this procedure in New York. The actual in-hospital mortality rates in the four years the system has been in operation are as follows:

| <u>Year</u> | <u>Mortality Rate</u> |
|-------------|-----------------------|
| 1989 | 3.52% |
| 1990 | 3.14% |
| 1991 | 3.08% |
| 1992 | 2.72% |

The actual mortality rate decreased substantially (by 23%) during this period despite the fact that the average severity of illness of patients undergoing surgery increased. Also, the concomitant decrease in the actual mortality rate and increase in average patient severity of illness led to an even larger 35% decrease in risk-adjusted mortality rate from 4.26% in 1989 to 2.72% in 1991. The risk-adjusted mortality rate is a measure of outcome after having adjusted for differences in patient severity.

In 1991, the Department of Health instituted a similar program in coronary angioplasty, and efforts have already begun to collect data related to the care of trauma patients and neonatal intensive care patients in preparation for assessing provider outcomes.

CORONARY ARTERY BYPASS GRAFT SURGERY

**in
New York State**

1989-1991

New York State Department of Health

December 1992 ○

New York State Department of Health

Members of the State Cardiac Advisory Committee

November 20, 1992

Chair

John W. Kirklin, M.D.
Department of Surgery
The University of Alabama at Birmingham
Birmingham, AL

Members

Djavad T. Arani, M.D.
Clinical Associate Professor of Medicine
SUNY at Buffalo School of Medicine
Buffalo, NY

James A. DeWeese, M.D.
Strong Memorial Hospital
Rochester, NY

Mary Allen Engle, M.D.
Professor Emeritus
New York Hospital - Cornell
New York, NY

O. Wayne Isom, M.D.
New York Hospital - Cornell
New York, NY

Lewis Johnson, M.D.
Director, Cardiac Catheterization Laboratory
St. Joseph's Hospital
Syracuse, NY

Mo Katz
Commonwealth Fund
New York, NY

Rae-Ellen Kavey, M.D.
Associate Professor
Division of Pediatric Cardiology
SUNY Health Science Center
Syracuse, NY

James A. Manning, M.D.
Director
Pediatric Care Section
Strong Memorial Hospital
Rochester, NY

Ben D. McCallister, M.D.
Cardiovascular Consultants, Inc.
Kansas City, MO

Barbara J. McNeil, M.D., Ph.D.
Head - Department of Health Care Policy
Harvard Medical School
Boston, MA

Jan M. Quaegebeur, M.D., Ph.D.
Department of Surgery
Columbia-Presbyterian Hospital
New York, NY

Robert Replogle, M.D.
Chief of Thoracic Surgery
Ingalls Hospital
Harvey, IL

Eric Rose, M.D.
Director, Division of Cardiothoracic Surgery
Presbyterian Hospital
New York, NY

Thomas J. Ryan, M.D.
Chief of Cardiology
Boston University Medical Center
Boston, MA

Rev. Robert S. Smith
Director, Spiritual Care
University Hospital, Health Sciences Center
SUNY at Stony Brook
Stony Brook, NY

Julio Sosa, M.D.
Albany Associates in Cardiology
Albany, NY

Denis Tyras, M.D.
Chief, Cardiothoracic Surgery
St. Vincent's Hospital and Medical Center
New York, NY

Frank Cole Spencer, M.D.
Professor and Chairman
Surgery Department
New York University Medical Center
New York, NY

Foreword

This report details a significant success story, which attests to the ability of surgeons, hospitals and the state Department of Health to work together to improve the quality of services offered to coronary artery bypass surgery patients in New York State.

Simply put, with the number of operations done each year increasing, and the severity of patient illness also increasing, the mortality rate has declined markedly. This is obviously excellent news for patients who need bypass surgery in New York State. Though precisely comparable national numbers are not available, all evidence indicated that the record in New York State is better than that achieved elsewhere in the country. It is also notable that the highest quality surgery is available throughout this large and diverse state, not just in Manhattan.

The coronary bypass surgery study and the results presented here are the result of a unique collaboration. A Cardiac Advisory Committee (CAC) composed of practicing cardiac surgeons and others in the field — from New York and elsewhere — has committed itself to set standards and goals for the cardiac surgery centers and

physicians in the state. The hospitals and physicians engaged in this practice have voluntarily participated in a special effort to collect and share precise and meaningful data about their patients and the outcome of surgery. Using a risk-adjustment formula crafted with the CAC, the Department of Health is then able to compile and provide to the hospitals and physicians involved a clear picture of their own performance, and its relationship to the performance of others. This allows comparison, and most importantly, has identified opportunities for quality improvement. Hospitals and physicians are taking advantage of these positive opportunities.

The Department of Health believes that the information that helps facilities and physicians make these improvements can also be valuable to prospective patients and their families. The CAC agrees, and has recommended that the Department publish this report and annual updates in years to come. The Department will work with the physicians and hospitals to assure that patients have the widest possible access to this information, and an opportunity to discuss it with their physicians.



Mark R. Chassin, M.D., Commissioner
New York State Department of Health

INTRODUCTION

The New York State Department of Health has a long-standing program designed to improve outcomes in persons with heart disease. This program has been directed toward

- (1) understanding the characteristics of individual patients which adversely affect outcomes,
- (2) improving the results of interventional and noninterventional treatment of heart disease,
- (3) improving the provision of cardiac care, and,
- (4) providing information to the public that allows individuals to make better informed decisions about their own care.

An essential feature of the program are sophisticated statistical analyses of the effect of patient and treatment characteristics (described here as significant risk factors) on patient outcome. These studies were developed by the Department under the guidance of the New York State Cardiac Advisory Committee, consisting of independent practicing cardiac surgeons, cardiologists and other professionals in related fields.

The resulting information allows an assessment of the performance of surgeons and hospitals over time, independent of the severity of the individual patient's pre-operative condition.

This report describes the program and evaluates the performance of hospitals and surgeons in New York State in terms of hospital deaths after coronary artery bypass graft (CABG) surgery.

RESULTS SUMMARY

From the beginning of this phase of the cardiac program in 1989, through 1991 (the latest year for which data are available), the improvement in cardiac surgery outcomes has been dramatic. The number of coronary artery bypass operations rose from 12,269 in 1989 to 14,944 in 1991, and the patients operated on had higher pre-operative risks overall. Still, mortality decreased. The key indicator, risk-adjusted mortality, dropped from 4.25% in 1989 to 2.72% in 1991, a 36% decrease.

DATA AND METHODOLOGY

For each patient receiving major cardiac surgery who was discharged on or after January 1, 1989, the cardiac surgery department of the hospital at which the surgery was performed has filled out a two page form that contains demographic information; patient, hospital, and surgeon identifiers; preoperative risk factors; complications during surgery or post-surgical care; dates of admission, discharge, and surgery; and discharge disposition (alive or dead). Cardiac surgery departments then

transfer this information to a personal computer diskette using data entry software that contains edit checks for various data entry omissions, errors, and inconsistencies. The diskettes are then sent each calendar quarter to the Department of Health, which acts as the data coordinating and analysis center.

METHODS USED AND PRODUCTS DEVELOPED

In order to use these data for the purposes outlined above, it was necessary to determine which of the preoperative risk factors contained on the form were significant predictors of adverse outcomes, and how to weight these risk factors in order to predict the chance of any given patient experiencing an adverse outcome. For example, an 80-year-old patient with diabetes and a previous myocardial infarction (heart attack) will have a higher risk of dying in the hospital than a 40-year-old patient with no significant risk factors. This information is provided to hospitals annually on a personal computer diskette that enables them to predict the risk of in-hospital mortality for each patient being considered for CABG surgery based on the patient's mix of risk factors.

It was also necessary to adjust the outcomes for each hospital so that differences in the average patient severity of illness would be accounted for, and hospitals treating the most severely ill patients would not be unfairly penalized. This "risk-adjusted" mortality rate, also called the indirectly standardized mortality rate, is an estimate of what a hospital's mortality rate would have been if its patients had exactly the same risk factors as all other hospitals.

Risk-adjusted mortality rates are calculated for each hospital performing CABG surgery and this information has been provided to hospitals and the public in 1989 and 1990. Each hospital is also given a personal computer diskette each year containing software that enables it to calculate the risk-adjusted mortality rates for each of its surgeons for any specified period during the year.

QUALITY IMPROVEMENT ACTIVITIES

In addition to providing useful information to each participating hospital, both the Cardiac Advisory Committee and the Department of Health are involved in more active quality improvement. The Cardiac Advisory Committee, assisting in the interpretation of data, advises the Department on which hospital surgery programs need special attention. Committee members have also conducted

site visits to certain hospitals, and recommended that other facilities be directed to obtain outside consultant experts to design improvements for their programs. The Committee and the Department also directed that all participating hospitals conduct a specific review of all surgeons performing fewer than 50 coronary artery bypass operations a year at that facility, and of 11 surgeons with a risk adjusted mortality exceeding 150% of the statewide rate.

Hospitals have taken different steps to deal with the issues involved. Some were placed on probation. In one case, a hospital suspended its program temporarily while making changes. Some surgeons were replaced. Other programs refined patient selection criteria. Facilities have begun evaluating patients more closely for pre-operative risk and directing patients to the appropriate surgeon. The overall results of this ongoing review demonstrate that significant progress is being made.

TESTING ABILITY OF STATISTICAL MODEL TO PREDICT MORTALITY

The risk-adjustment process consists of using statewide information to predict a patient's chance of dying during or after CABG surgery before being discharged from the hospital. These predictions are in turn used in the process of calculating risk-adjusted mortality rates, and in assessing hospital and surgeon performance. A legitimate concern of hospitals, surgeons, and consumers is that the predictions on which the assessments are based are

sufficiently accurate. This is of particular concern for the most difficult cases, because if the system underestimates their risk, there may be an incentive for surgeons not to operate on these patients. Table 1 presents the actual and predicted (expected) mortality rates for patients at various levels of risk, as measured by ranges of predicted mortality rates. Ranges were chosen so that the predicted number of deaths in each range was equal.

The actual and predicted mortality rates for each group of patients were remarkably similar. There is no tendency for the model to predict fewer deaths among the two groups of patients who are the most severely ill. For example, the model predicts that 47.7% of patients in the highest risk group would die following surgery, and 42.6% did die. There were no statistically significant differences between actual and predicted deaths in any of the ten subgroups studied. This analysis leads us to conclude that the model is sufficiently accurate for the purpose of adjusting mortality rates to account for differences in severity of illness.

RESULTS

1991 Risk Factors

The significant preoperative risk factors in 1991 and their "odds ratios" are presented in Table 2.

Roughly speaking, the odds ratio for a risk factor represents the number of times more likely a patient with the risk factor is of dying in the hospital during

Table 1: Actual and expected percent hospital mortality (statewide) according to severity of patient illness, using the multivariable equation for 1989, 1990, and 1991. The P-value is for the difference between actual and expected number of hospital deaths

| Range of Expected % Survival | Patients (n) | Hospital Deaths (Number) | | | Hospital Deaths % Mortality | |
|---------------------------------|-----------------|-----------------------------|----------|------------|--------------------------------|----------|
| | | Actual | Expected | P for diff | Actual | Expected |
| 22- 1.33 | 14304 | 117 | 133 | 16 | 0.82 | 0.93 |
| 1.34- 1.97 | 8253 | 121 | 133 | 3 | 1.47 | 1.61 |
| 1.98- 2.73 | 5748 | 141 | 133 | 5 | 2.45 | 2.32 |
| 2.74- 3.77 | 4146 | 130 | 133 | 8 | 3.14 | 3.21 |
| 3.78- 5.15 | 3034 | 143 | 133 | 4 | 4.71 | 4.39 |
| 5.16- 7.15 | 2207 | 152 | 133 | .09 | 6.89 | 6.03 |
| 7.16-10.52 | 1546 | 142 | 133 | 4 | 9.19 | 8.61 |
| 10.53-16.41 | 1029 | 139 | 133 | 6 | 13.51 | 12.94 |
| 16.42-31.17 | 615 | 127 | 133 | .5 | 20.65 | 21.68 |
| 31.29-97.03 | 277 | 118 | 132 | .09 | 42.60 | 47.71 |
| Total | 41159 | 1330 | | | 3.23% | |

Table 2 Multivariable risk factor equation for hospital deaths in New York State in 1991.

| Patient Risk Factors for Hospital Deaths | Logistic | | Odds Ratio |
|--|-------------|---------|------------|
| | Coefficient | P-value | |
| Demographic | | | |
| Age | 0.0323 | <.0001 | 1.03 |
| Female Gender | 0.4096 | .0002 | 1.51 |
| Coronary Disease | | | |
| Left Main Stenosis >50% | 0.2425 | .0349 | 1.27 |
| 3-System Stenoses >70% | 0.2633 | .0207 | 1.30 |
| Myocardial Ischemia | | | |
| CCS Class IV | 0.2435 | .0418 | 1.28 |
| Ventricular Function | | | |
| Previous MI <6 hours | 0.6104 | .0279 | 1.84 |
| Ejection Fraction < 20 | 0.8503 | .0025 | 2.34 |
| Ejection Fraction .20-.39 | 0.4412 | .0001 | 1.55 |
| Secondary Conditions | | | |
| Congestive Heart Failure | 0.3561 | .0044 | 1.43 |
| IABP Pre-op | 0.4289 | .0208 | 1.54 |
| ECG Evidence, Left Ventricular Hypertrophy | 0.3581 | .0039 | 1.43 |
| Persistent Ventricular Arrhythmia | 0.4526 | .0246 | 1.57 |
| Severity of Atherosclerotic Process | | | |
| Coexisting Carotid Disease | 0.4936 | .0002 | 1.64 |
| Aortoiliac Disease | 0.3228 | .0350 | 1.38 |
| Calcified Aorta | 0.6201 | .0002 | 1.86 |
| Secondary Conditions | | | |
| Hemodynamic Instability | 1.0152 | < .0001 | 2.76 |
| Shock | 1.9400 | < .0001 | 6.96 |
| Renal Failure | 1.0564 | .0001 | 2.88 |
| Hepatic Failure | 1.6951 | .0261 | 5.45 |
| Nonelective Surgery | 0.3246 | .0147 | 1.38 |
| Previous Open Heart Operation (> 1) | 1.2324 | < .0001 | 3.43 |

or after CABG surgery than a patient without the risk factor, all other risk factors being the same. For example, the odds ratio for the risk factor "congestive heart failure" is 1.43. This means that a patient with congestive heart failure is approximately 1.43 times as likely to die in the hospital as a patient without congestive heart failure who has the same other significant risk factors.

For most of the risk factors in the table, there are only two possibilities: having the risk factor or not having it (for example, a patient either has congestive heart failure or does not have it). Exceptions are age and ejection fraction. Ejection fraction, which is a measure of the ability of the heart's left ventricle to expel blood when it contracts, has two categories representing additional risk: less than 20% and between 20% and 39%. Odds ratios for both of these risk categories are relative to patients with ejection fractions 40% or higher. The odds ratio for age pertains to the risk

that is incurred with each additional year of age. That is, an individual 50 years old receiving CABG surgery is about 1.03 times as likely to expire in the hospital as a person 49 years of age undergoing CABG surgery, and an individual 75 years of age is about 1.03 times as likely as a person 74 years old of dying in the hospital.

1991 HOSPITAL OUTCOMES

Table 3 presents the 1991 CABG surgery results for the 30 hospitals performing this operation in New York. (Another hospital, Ellis Hospital, began performing CABG surgery at the end of 1991 but its results are not presented here because a very small number of operations were performed).

The table contains, for each hospital, the number of isolated CABG operations performed in 1991, the number of in-hospital deaths, the actual mortality

Table 3: Actual, expected, and risk-adjusted % hospital mortality after coronary artery bypass grafting in 1991, according to hospital

| Hospital | Patients (n) | Hospital Deaths | | Risk-Adjusted % Mortality | | |
|------------------------|--------------|-----------------|-------------------------------------|---------------------------|--------|----------------------------|
| | | No. | Actual (Observed) % Mortality | Expected % Mortality | % | 95% Confidence Limits (CL) |
| Albany Medical Center | 831 | 26 | 3.13 | 2.85 | 3.38 | 2.20-4.95 |
| Arnot-Ogden | 466 | 13 | 2.79 | 2.14 | 4.01 | 2.13-6.85 |
| Bellevue | 59 | 4 | 6.78 | 2.81 | 7.42 | 2.00-19.00 |
| Beth Israel | 169 | 4 | 2.37 | 3.05 | 2.39 | 0.64-6.11 |
| Binghamton General | 325 | 8 | 2.46 | 3.35 | 2.26 | 0.98-4.46 |
| Buffalo General | 1151 | 26 | 2.26 | 2.52 | 2.76 | 1.80-4.04 |
| Erie County | 148 | 5 | 3.38 | 1.93 | 5.39 | 1.74-12.59 |
| Lenox Hill | 507 | 18 | 3.55 | 3.17 | 3.45 | 2.04-5.45 |
| Long Island Jewish | 369 | 13 | 3.52 | 2.70 | 4.02 | 2.14-6.88 |
| Maimonides | 608 | 22 | 3.62 | 3.63 | 3.07 | 1.92-4.64 |
| Millard Fillmore | 496 | 15 | 3.02 | 2.44 | 3.82 | 2.14-6.30 |
| Montefiore Moses | 305 | 5 | 1.64 | 2.82 | 1.79 | 0.58-4.18 |
| Montefiore Weiler | 196 | 0 | 0.00 | 2.29 | 0.00** | 0.00-2.51 |
| Mount Sinai | 497 | 15 | 3.02 | 2.84 | 3.28 | 1.83-5.40 |
| New York Hospital | 831 | 23 | 2.77 | 3.77 | 2.26 | 1.43-3.39 |
| North Shore | 465 | 16 | 3.44 | 3.25 | 3.25 | 1.86-5.28 |
| NYU Medical Center | 707 | 31 | 4.38 | 5.38 | 2.51 | 1.70-3.56 |
| Presbyterian | 275 | 10 | 3.64 | 2.95 | 3.80 | 1.82-6.99 |
| Rochester General | 959 | 22 | 2.29 | 3.40 | 2.08 | 1.30-3.15 |
| St. Francis | 1261 | 31 | 2.46 | 3.10 | 2.44 | 1.66-3.47 |
| S. Joseph's | 521 | 11 | 2.11 | 2.56 | 2.53 | 1.26-4.54 |
| St. Luke's | 734 | 24 | 3.27 | 2.44 | 4.12 | 2.64-6.13 |
| St. Peter's | 437 | 20 | 4.58 | 2.12 | 6.64* | 4.06-10.26 |
| St. Vincent's | 481 | 22 | 4.57 | 2.13 | 6.61* | 4.14-10.01 |
| Strong Memorial | 331 | 14 | 4.23 | 3.64 | 3.57 | 1.95-5.99 |
| Univ. Hosp. Brooklyn | 216 | 12 | 5.56 | 2.37 | 7.21* | 3.72-12.59 |
| University Hospital | 277 | 9 | 3.25 | 5.27 | 1.90 | 0.87-3.60 |
| Upstate Medical Center | 266 | 12 | 4.51 | 2.71 | 5.12 | 2.64-8.95 |
| Westchester Co. | 605 | 18 | 2.98 | 2.66 | 3.44 | 2.04-5.44 |
| Winthrop | 451 | 11 | 2.44 | 4.24 | 1.77 | 0.88-3.17 |
| Total | 14944 | 460 | 3.08 (95% CL 2.81%- 3.37%) | | | |

*Risk-Adjusted % hospital mortality is higher than statewide rate ($P < 0.05$)**Risk-Adjusted % hospital mortality is lower than statewide rate ($P < 0.05$)

Note: Confidence limits quantify the variability that is inherent in the statement of risk-adjusted % mortality. One cannot be certain that the risk-adjusted mortality for Albany Medical Center, for example, is 3.38%, but can be 95% certain that (in this study) it was somewhere between 2.20% and 4.95%.

rate, the expected mortality rate, the risk-adjusted mortality rate, and a 95% confidence interval for the risk-adjusted mortality rate. Also included are the number of operations, deaths, and actual mortality rate for the entire state. Expected mortality rate is a measure of the difficulty of the CABG operations performed at a hospital; higher expected rates correspond to more difficult cases on average. The confidence interval can be regarded as the range within which we are 95% confident that the long-term risk-adjusted mortality rate for the hospital lies.

Note that 14,944 isolated CABG operations were performed statewide in 1991, with a mortality rate of 3.08%. Hospital risk-adjusted mortality rates ranged from 0.00% to 7.42%. One hospital (Montefiore Weiler) had a risk-adjusted mortality rate significantly lower than the statewide rate of 3.08% (as evidenced by the upper limit of the confidence interval for its risk-adjusted rate (2.51%) being less than 3.08%), and three hospitals (St. Peter's, St. Vincent's, and University Hospital at Brooklyn (Downstate Medical Center)) had risk-adjusted rates significantly higher than the statewide rate, as evidenced by the lower limit of the confidence intervals for their risk-adjusted rates being higher than 3.08%.

1989-1991 STATEWIDE DATA

Table 4, which is based on statistical analyses of all three years of data now available, presents annual statewide information regarding the volume, actual mortality rate, expected mortality rate, and risk-adjusted mortality rate for isolated CABG surgery in New York.

As indicated in Table 4, the volume of isolated CABG operations in New York rose 12.0% from 12,269 to 13,946 between 1989 and 1990 and rose 7.2% to 14,944 from 1990 to 1991. This was accompanied by a drop in actual in-hospital mortality rates from 3.52% to 3.14% to 3.08% in the three year period. The actual mortality rate

decreased during the period despite the fact that the average severity of illness of patients undergoing surgery increased, as evidenced by the increase in expected mortality rate from 2.68% in 1989 to 3.66% in 1991. The concomitant decrease in the actual mortality rate and increase in average patient severity of illness led to a large decrease in risk-adjusted mortality rate from 4.25% in 1989 to 2.72% in 1991. Since the risk-adjusted mortality rate is a measure of outcome after having adjusted for differences in patient severity, these data are evidence of a major improvement in CABG surgery results during the three year period.

1989-1991 HOSPITAL AND SURGEON DATA

Table 5 provides the number of isolated CABG operations, number of CABG patients who died in the hospital, actual mortality rate, expected mortality rate, and risk-adjusted mortality rate for 1989-1991 for each of the 30 hospitals performing CABG surgery during the time period. The same information, listed by hospital in which the operations were performed, is presented for surgeons who performed 200 or more isolated CABG operations in that hospital during 1989-1991. The results for surgeons who performed fewer than 200 isolated CABG operations are not presented by surgeon name because, in the judgment of the Department of Health, the volumes are not high enough to be indicative of future performance. Instead, these data are grouped together and reported as "other cases" in the hospital in which the operations were performed. Surgeons who performed operations in more than one hospital are noted in the table and are listed in all hospitals in which they performed 200 or more operations. Also, surgeons and hospitals with risk-adjusted mortality rates that are significantly lower or higher than the statewide mortality rate are noted in the table.

Table 4: Actual, expected, and risk-adjusted hospital mortality after coronary artery bypass surgery, 1989-1991.

| Hospital Mortality | 1989 (n = 12,269) | 1990 (n = 13,946) | 1991 (n = 14,944) |
|--------------------|----------------------|----------------------|----------------------|
| Actual | 3.52% | 3.14% | 3.08% |
| Expected | 2.68% | 3.26% | 3.66% |
| Risk-Adjusted | 4.25% | 3.11% | 2.72% |

Table 5: Actual, expected, and risk-adjusted hospital and surgeon mortality after coronary artery bypass grafting, 1989-1991.

| Surgeon | Patients (n) | Hospital Deaths | | Risk-Adjusted % Mortality | | |
|---------------------------------------|-----------------|-----------------|--|----------------------------|--------|-----------------------------|
| | | No. | Actual (Observed) % Mortality | Expected % Mortality | % | 95% Confidence Limits |
| Albany Medical Center Hospital | | | | | | |
| #Britton L | 413 | 8 | 1.94 | 2.80 | 2.24 | 0.96-4.41 |
| Canavan T | 452 | 13 | 2.88 | 2.41 | 3.85 | 2.05-6.59 |
| Foster E | 250 | 7 | 2.80 | 2.37 | 3.82 | 1.53-7.87 |
| Older T | 339 | 18 | 5.31 | 3.29 | 5.21 | 3.09-8.24 |
| All Others (8) | 604 | 25 | 4.14 | 3.20 | 4.18 | 2.70-6.16 |
| TOTAL | 2058 | 71 | 3.45 | 2.86 | 3.90 | 3.04-4.91 |
| Arnot-Ogden Memorial Hospital | | | | | | |
| Borja A. | 544 | 22 | 4.04 | 3.19 | 4.10 | 2.57-6.21 |
| Quintos E. | 336 | 12 | 3.57 | 3.11 | 3.70 | 1.91-6.47 |
| Vaughan J. | 496 | 13 | 2.62 | 2.89 | 2.93 | 1.56-5.01 |
| All Others (2) | 90 | 4 | 4.44 | 2.49 | 5.76 | - |
| TOTAL | 1466 | 51 | 3.48 | 3.03 | 3.71 | 2.76-4.88 |
| Bellevue Hospital Center | | | | | | |
| TOTAL | 188 | 9 | 4.79 | 3.34 | 4.63 | 2.11-8.78 |
| Beth Israel Medial Center | | | | | | |
| TOTAL | 317 | 8 | 2.52 | 3.75 | 2.17 | 0.94-4.29 |
| Binghamton General Hospital | | | | | | |
| Cunningham JR | 399 | 8 | 2.01 | 2.68 | 2.42 | 1.04-4.77 |
| #Yousuf M | 398 | 6 | 1.51 | 3.23 | 1.51 | 0.55-3.28 |
| All Others (1) | 48 | 2 | 4.17 | 2.54 | 5.31 | - |
| TOTAL | 845 | 16 | 1.89 | 2.93 | 2.09 | 1.19-3.39 |
| Buffalo General Hospital | | | | | | |
| Bergsland J | 562 | 8 | 1.42 | 2.52 | 1.83 | 0.79-3.60 |
| Bhayana J | 616 | 15 | 2.44 | 2.68 | 2.93 | 1.64-4.84 |
| Lajos T | 589 | 29 | 4.92 | 3.14 | 5.07* | 3.39-7.28 |
| Lewin A | 719 | 14 | 1.95 | 2.42 | 2.60 | 1.42-4.37 |
| Raza S | 570 | 11 | 1.93 | 2.59 | 2.41 | 1.20-4.31 |
| All Others (3) | 154 | 8 | 5.19 | 2.72 | 6.18 | - |
| TOTAL | 3210 | 85 | 2.65 | 2.66 | 3.21 | 2.57-3.97 |
| Erie County Medical Center | | | | | | |
| TOTAL | 364 | 15 | 4.12 | 1.82 | 7.31* | 4.09-12.07 |
| Lenox Hill Hospital | | | | | | |
| Subramanian V | 913 | 29 | 3.18 | 3.93 | 2.61 | 1.75-3.75 |
| All Others (2) | 228 | 4 | 1.75 | 3.02 | 1.88 | 0.51-4.81 |
| TOTAL | 1141 | 33 | 2.89 | 3.75 | 2.49 | 1.72-3.50 |
| Long Island Jewish Med. Center | | | | | | |
| Graver L | 378 | 15 | 3.97 | 4.00 | 3.21 | 1.79-5.29 |
| #Tyras D | 366 | 2 | 0.55 | 2.61 | 0.68** | 0.08-2.44 |
| All Others (2) | 278 | 12 | 4.32 | 3.65 | 3.83 | 1.97-6.68 |
| TOTAL | 1022 | 29 | 2.84 | 3.41 | 2.69 | 1.80-3.87 |
| Maimonides Medical Center | | | | | | |
| #Cunningham JN | 332 | 12 | 3.61 | 3.03 | 3.86 | 1.99-6.74 |
| Jacobowitz I | 916 | 32 | 3.49 | 4.23 | 2.67 | 1.82-3.76 |
| Sabado M | 229 | 12 | 5.24 | 6.21 | 2.73 | 1.41-4.76 |
| All Others (4) | 87 | 8 | 9.20 | 3.43 | 8.67 | - |
| TOTAL | 1564 | 64 | 4.09 | 4.22 | 3.13 | 2.41-4.00 |

| | | | | | | |
|---|------|----|-------|------|--------|-----------|
| Millard Fillmore Hospital | | | | | | |
| Aldridge J | 297 | 8 | 2 69 | 2 07 | 4 20 | 1 81 8 28 |
| Guarino R | 268 | 8 | 2 99 | 2 28 | 4 22 | 1 82 8 32 |
| Major W | 270 | 6 | 2 22 | 2 53 | 2 84 | 1 04 6 18 |
| Walsh J | 336 | 11 | 3 27 | 2 68 | 3 95 | 1 97 7 06 |
| All Others (1) | 188 | 3 | 1 60 | 2 37 | 2 18 | |
| TOTAL | 1359 | 36 | 2 65 | 2 40 | 3 57 | 2 50 4 95 |
| Montefiore Medical Center - | | | | | | |
| Moses Division | | | | | | |
| Attai L | 345 | 6 | 1 74 | 3 03 | 1 86 | 0 68 4 04 |
| #Brodman R | 258 | 6 | 2 33 | 2 82 | 2 66 | 0 97 5 79 |
| Merav A | 320 | 10 | 3 13 | 3 36 | 3 01 | 1 44 5 53 |
| All Others (2) | 7 | 1 | 14 29 | 5 28 | 8 75 | |
| TOTAL | 930 | 23 | 2 47 | 3 10 | 2 58 | 1 63 3 87 |
| Montefiore Medical Center - | | | | | | |
| Weiler Hospital | | | | | | |
| #Sisto D | 413 | 7 | 1 69 | 3 01 | 1 82 | 0 73 3 75 |
| All Others (1) | 172 | 4 | 2 33 | 2 90 | 2 59 | |
| TOTAL | 585 | 11 | 1 88 | 2 97 | 2 04 | 1 02 3 66 |
| Mount Sinai Hospital | | | | | | |
| #Ergin M | 579 | 9 | 1 55 | 3 93 | 1 28** | 0 58 2 43 |
| #Lansman S | 398 | 14 | 3 52 | 4 23 | 2 69 | 1 47 4 51 |
| All Others (4) | 507 | 16 | 3 16 | 3 28 | 3 11 | 1 78 5 05 |
| TOTAL | 1484 | 39 | 2 63 | 3 79 | 2 24** | 1 60 3 07 |
| New York Hospital | | | | | | |
| Gold J | 255 | 3 | 1 18 | 4 49 | 0 85** | 0 17 2 47 |
| Isom O | 468 | 14 | 2 99 | 3 66 | 2 64 | 1 44 4 43 |
| Krieger K | 959 | 23 | 2 40 | 3 79 | 2 05** | 1 30 3 07 |
| Lang S | 740 | 32 | 4 32 | 4 50 | 3 11 | 2 13 4 39 |
| All Others (2) | 117 | 3 | 2 56 | 2 89 | 2 86 | |
| TOTAL | 2539 | 75 | 2 95 | 4 00 | 2 39** | 1 88 2 99 |
| North Shore University Hospital | | | | | | |
| Hall M | 579 | 32 | 5 53 | 4 01 | 4 45 | 3 04 6 28 |
| Nelson R | 243 | 17 | 7 00 | 4 38 | 5 16 | 3 00 8 26 |
| Tortolani A | 416 | 22 | 5 29 | 3 03 | 5 64* | 3 54 8 55 |
| All Others (3) | 91 | 2 | 2 20 | 3 60 | 1 97 | |
| TOTAL | 1329 | 73 | 5 49 | 3 74 | 4 74* | 3 72 5 96 |
| New York University Medical Center | | | | | | |
| #Colvin S | 273 | 9 | 3 30 | 4 97 | 2 15 | 0 98 4 07 |
| Culliford A | 387 | 7 | 1 81 | 3 41 | 1 71 | 0 69 3 53 |
| Esposito R | 293 | 11 | 3 75 | 5 44 | 2 23 | 1 11 3 99 |
| #Galloway A | 285 | 10 | 3 51 | 2 83 | 4 01 | 1 92 7 38 |
| #Ribakove G | 254 | 13 | 5 12 | 5 42 | 3 05 | 1 62 5 22 |
| Spencer F | 316 | 12 | 3 80 | 3 50 | 3 50 | 1 81 6 12 |
| All Others (4) | 309 | 14 | 4 53 | 4 43 | 3 31 | 1 81 5 55 |
| TOTAL | 2117 | 76 | 3 59 | 4 22 | 2 75 | 2 17 3 44 |
| Presbyterian Hospital - | | | | | | |
| City of New York | | | | | | |
| Rose E | 362 | 12 | 3 31 | 3 52 | 3 04 | 1 57 5 31 |
| Smith C | 255 | 4 | 1 57 | 2 28 | 2 22 | 0 60 5 68 |
| All Others (4) | 175 | 7 | 4 00 | 2 95 | 4 38 | |
| TOTAL | 792 | 23 | 2 90 | 3 00 | 3 13 | 1 98 4 70 |

| | | | | | | |
|---|------|----|-------|------|--------|-----------|
| Rochester General Hospital | | | | | | |
| Cheeran D | 606 | 16 | 2.64 | 2.56 | 3.33 | 190-5.41 |
| Kirshner R | 498 | 14 | 2.81 | 3.63 | 2.50 | 137-4.20 |
| Knight P | 619 | 15 | 2.42 | 3.53 | 2.22 | 124-3.66 |
| Mijangos J | 833 | 25 | 3.00 | 3.83 | 2.53 | 164-3.74 |
| All Others (1) | 107 | 4 | 3.74 | 3.39 | 3.56 | - |
| TOTAL | 2663 | 74 | 2.78 | 3.42 | 2.63 | 206-3.30 |
| St. Francis Hospital | | | | | | |
| Damus P | 706 | 6 | 0.85 | 2.64 | 1.04** | 038-2.26 |
| Durban L | 369 | 10 | 2.71 | 4.62 | 1.90 | 091-3.49 |
| Hartstein M | 472 | 12 | 2.54 | 2.75 | 2.98 | 154-5.21 |
| Robinson N | 697 | 14 | 2.01 | 3.26 | 1.99 | 109-3.34 |
| Weisz D | 537 | 20 | 3.72 | 2.91 | 4.13 | 252-6.38 |
| Wisoff B | 508 | 13 | 2.56 | 3.31 | 2.50 | 133-4.27 |
| All Others (4) | 158 | 13 | 8.23 | 3.98 | 6.68 | - |
| TOTAL | 3447 | 88 | 2.55 | 3.20 | 2.58** | 207-3.18 |
| St. Joseph's Hospital Health Center | | | | | | |
| Levy I | 341 | 17 | 4.99 | 2.59 | 6.21* | 362-9.95 |
| #Marvasti M | 501 | 9 | 1.80 | 2.63 | 2.20 | 101-4.18 |
| #Rosenberg J | 512 | 4 | 0.78 | 2.82 | 0.90** | 024-2.29 |
| All Others (3) | 94 | 2 | 2.13 | 2.51 | 2.74 | - |
| TOTAL | 1448 | 32 | 2.21 | 2.68 | 2.66 | 182-3.76 |
| St. Lukes Roosevelt Hospital - St. Lukes Hospital Division | | | | | | |
| Green G | 435 | 11 | 2.53 | 1.84 | 4.45 | 222-7.96 |
| Mindich B | 516 | 19 | 3.68 | 2.68 | 4.44 | 267-6.93 |
| Swistel D | 457 | 22 | 4.81 | 3.38 | 4.60 | 288-6.97 |
| Zadeh B | 644 | 20 | 3.11 | 3.45 | 2.91 | 178-4.50 |
| All Others (3) | 41 | 4 | 9.76 | 4.02 | 7.84 | - |
| TOTAL | 2093 | 76 | 3.63 | 2.92 | 4.02 | 317-5.03 |
| St. Peters Hospital | | | | | | |
| #Depan H | 216 | 12 | 5.56 | 2.81 | 6.38* | 329-11.15 |
| #McIluff J | 315 | 5 | 1.59 | 2.33 | 2.21 | 071-5.15 |
| #Miller S | 323 | 13 | 4.02 | 2.60 | 5.01 | 266-8.57 |
| All Others | 91 | 4 | 4.40 | 2.31 | 6.15 | - |
| TOTAL | 945 | 34 | 3.60 | 2.53 | 4.60 | 318-6.43 |
| St. Vincent's Hospital and Medical Center | | | | | | |
| #Acinapura A | 449 | 19 | 4.23 | 2.99 | 4.58 | 276-7.15 |
| McGinn J | 208 | 7 | 3.37 | 3.09 | 3.52 | 141-7.25 |
| All Others (6) | 449 | 28 | 6.24 | 2.82 | 7.14* | 474-10.32 |
| TOTAL | 1106 | 54 | 4.88 | 2.94 | 5.37* | 403-7.00 |
| Strong Memorial Hospital | | | | | | |
| Hicks G | 748 | 21 | 2.81 | 3.33 | 2.72 | 168-4.16 |
| Stewart S | 216 | 20 | 9.26 | 3.08 | 9.71* | 593-15.00 |
| All Others (1) | 39 | 5 | 12.82 | 4.01 | 10.34 | - |
| TOTAL | 1003 | 46 | 4.59 | 3.30 | 4.49* | 328-5.98 |
| State University Hospital Upstate Medical Center | | | | | | |
| Brandt B | 231 | 9 | 3.90 | 2.86 | 4.40 | 201-8.35 |
| #Parker F | 314 | 8 | 2.55 | 2.69 | 3.06 | 132-6.03 |
| All Others (3) | 206 | 8 | 3.88 | 2.20 | 5.71 | 246-11.25 |
| TOTAL | 751 | 25 | 3.33 | 2.61 | 4.12 | 267-6.09 |

| | | | | | | |
|--------------------------------------|-------|------|------|------|-------|------------|
| University Hospital (Stony Brook) | | | | | | |
| Hartman A | 318 | 7 | 2 20 | 3 90 | 1 82 | 0 73 3 75 |
| All Others (3) | 369 | 16 | 4 34 | 5 43 | 2 58 | 1 47 4 19 |
| TOTAL | 687 | 23 | 3 35 | 4 73 | 2 29 | 1 45 3 44 |
| University Hosp. of Brooklyn | | | | | | |
| # Zisbrod Z | 374 | 17 | 4 55 | 2 92 | 5 04 | 2 93 8 07 |
| All Others (7) | 294 | 23 | 7 82 | 3 20 | 7 90* | 5 00 11 85 |
| TOTAL | 668 | 40 | 5 99 | 3 04 | 6 36* | 4 54 8 66 |
| Westchester County Med Ctr | | | | | | |
| # Moggio R | 370 | 9 | 2 43 | 2 74 | 2 87 | 1 31 5 44 |
| Pooley R | 330 | 14 | 4 24 | 2 63 | 5 22 | 2 85 8 76 |
| Sarabu M | 331 | 8 | 2 42 | 2 97 | 2 63 | 1 13 5 18 |
| All Others (8) | 821 | 23 | 2 80 | 2 62 | 3 45 | 2 19 5 18 |
| TOTAL | 1852 | 54 | 2 92 | 2 71 | 3 48 | 2 61 4 54 |
| Winthrop - Univ. Hosp | | | | | | |
| Mohhtashemi M | 224 | 8 | 3 57 | 2 74 | 4 21 | 1 81 8 29 |
| Scott W | 226 | 6 | 2 65 | 3 98 | 2 15 | 0 79 4 69 |
| All Others (7) | 736 | 33 | 4 48 | 2 78 | 5 22* | 3 59 7 33 |
| TOTAL | 1186 | 47 | 3 96 | 3 00 | 4 27 | 3 14 5 68 |
| <hr/> | | | | | | |
| Total | 41159 | 1330 | 3 23 | | | |

* RISK-ADJUSTED RATE IS SIGNIFICANTLY HIGHER THAN STATEWIDE RATE ($P < 0.05$)

**RISK-ADJUSTED RATE IS SIGNIFICANTLY LOWER THAN STATEWIDE RATE ($P < 0.05$)

PERFORMED OPERATIONS IN ANOTHER NEW YORK STATE HOSPITAL

##PERFORMED OPERATIONS IN TWO OTHER NEW YORK STATE HOSPITALS

NOTE ONLY SURGEONS PERFORMING 200 OR MORE OPERATIONS TOTAL IN 1989-1991 ARE LISTED
BY NAME

CONCLUSION

Mortality following CABG surgery improved substantially in New York State between 1989 and 1991. The Department of Health recognizes that new and improved surgical methods and improved training have been important in effecting this change. However, it is the opinion of the Department that the data reporting and analysis system, a product of the voluntary participation of institutions and surgeons, has also played an important role in achieving this outcome.

The Department of Health intends to continue to release annually the kind of information contained in this report. As our experience grows, both in the time periods covered and in the numbers of

patients included, the analyses can become more sophisticated and specific. The usefulness of the reports will thereby increase.

The usefulness of the report to the public may be limited by the fact that many of the risk factors are medical conditions that are unfamiliar to the lay person. Thus, individuals are advised to consult their physicians before concluding they do or do not have a given risk factor for death after CABG surgery. The public is also asked to remember that these data and analyses do not include information about the present, 1992. Predictions about current and future outcomes should be made with care, and with the assistance of qualified physicians and surgeons.

Corporate Headquarters
901 Manner s Island Boulevard
Suite 565
San Mateo, California 94404

(415) 349-9100



One Paces West, Suite 1640
2727 Paces Ferry Road, NW
Atlanta, Georgia 30339

(404) 333-0607

**Testimony of William Mohlenbrock, MD.
Co-Founder and Medical Director
Iameter, Inc.
San Mateo, California**

**Before The Regulation, Business Opportunities and Energy
Subcommittee
House Small Business Committee
Honorable Ron Wyden, Chairman**

June 28, 1993

INTRODUCTION

Mr. Chairman, and members of the Committee, we appreciate the opportunity to appear before the subcommittee to discuss the type of information which may be helpful to consumers in selecting and comparing health plans, including information on hospitals and physicians. We would also like to share our insights and experience regarding the limitations of current clinical data, the need for careful analysis and interpretation of clinical data and suggestions on the level of data which may be appropriate and helpful for public dissemination.

Among the issues we would like to highlight in our testimony are the following:

- Data that is disseminated, to any audience, must be clinically reliable and medically meaningful.
- We must protect against the release of clinically unreliable data which may unfairly portray a provider's responsibility for an adverse outcome.
- We need to ensure that both structure and process are taken into account, as the cause of an adverse patient outcome may or may not be in the control of an individual provider.
- And that data is not released which does not accurately reflect or explain possible causes for outcomes or variation such as case mix or severity adjustment.

Mr. Chairman, you have been a leader in promoting the need to disseminate information to consumers which can assist them in being better informed consumers of health care through your efforts to create the National Practitioner's Data Bank. We support that effort and hope that today's hearing will illuminate other areas where it may be appropriate to release medically meaningful and clinically reliable information to consumers.

CLINICAL DATA COLLECTION AND OUTCOMES MEASUREMENT

Common to every discussion of health care reform, regardless of political party, is the desire to increase the level of meaningful information which is available to health care patients, providers and purchasers. Iameter has been engaged in this endeavor for the past ten years. Thus, we are committed to the principle that clinically reliable and medically meaningful information is a critical component of any plan to successfully reform our nation's health care system.

Iameter is a medical information and education company based in San Mateo, California which was founded in 1983 by myself and my partner Dr. Peter Farley. We are dedicated to improving the quality and efficiency of health care by using severity-adjusted clinical outcomes information as a catalyst in our work with health care providers to improve both the processes and outcomes of health care delivery. As we have stated in numerous meetings on Capitol Hill, medically meaningful and credible clinical information - not just raw data - must be provided to health care providers on a regular basis, preferably in a quality improvement process. For we have found that only with this type of information can health care providers truly

understand their own practice patterns and variations compared to their peers and begin to identify ways to improve the processes and clinical outcomes of health care delivery.

HEALTH CARE PROVIDERS SHOULD BE HELD ACCOUNTABLE FOR THEIR MEDICAL PRACTICES

We believe that all health care providers should be held accountable for the care they render and this is best facilitated when they are given meaningful clinical information. Thus, we subscribe to and advocate adherence to the definition of health care quality developed by the Congressional Office of Technology Assessment and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) which states,

"The quality of a provider's medical care is the degree to which the process of care increases the probability of desired patient outcomes and reduces the probability of undesired outcomes given the state of medical knowledge."

To facilitate adherence to this definition, Iameter presents health care providers with hospital and physician specific profiles of clinical processes and outcomes. This data is the tool we employ in our work with providers to monitor and enhance their clinical quality outcomes and cost-efficiencies through a continuous quality improvement process. The quality curve attached with this testimony demonstrates visually what we seek to accomplish with providers. We use data in an internal evaluation process to help providers move along the quality curve to the point where quality and cost-efficiency are maximized.

With our Acuity Index Method (AIM), we use existing clinical data to institute an educational process with hospitals and physicians. AIM is a severity-of-illness classification system which provides hospitals, physicians, and payers with a tangible means to assess the effectiveness of their efforts to deliver quality, cost-efficient care.

The AIM algorithm was established on a database of more than 30 million cases across all Diagnosis Related Groups (DRGs) and all payers. Each DRG has its own unique algorithm, with an acuity rating from 1 (least sick) to 5 (most sick). The basis of the subdivisions involves the interrelationships and interactions of pathologic processes. Severity-adjusted norms for length of stay, charges and mortality rates are compared with actual case experience to differentiate quality and cost-efficient performance.

AIM enhances the DRG methodology by subdividing each DRG into patient groups based upon morbidity and mortality rates. Once we have subdivided the clinical information into the appropriate acuity index, we are able to analyze the outcomes by comparing comparable cases and providing this information to physicians.

The severity adjustment of this information is critically important, for releasing data that is not severity adjusted can be injurious to health care providers and misleading to the public. The importance of this type of analysis was underscored last week when Bruce Vladeck, Administrator of the Health Care Financing Administration, HCFA, said that HCFA will not release the hospital mortality rates for hospitals participating in the Medicare

program, citing problems with the data's usefulness as an indicator of quality.

INTERNAL VERSUS EXTERNAL DATA DISSEMINATION

Our focus in data collection and analysis is internally directed to facilitate improvement in clinical outcomes and cost-efficiency at the hospital and physician level. We believe that assessments of clinical quality and cost-efficiency are best made by physicians at the individual physician level, as our goal is to engage health care providers in a Continuous Quality Improvement (CQI) Process. This differs from state data disclosure efforts which seek to identify health care providers who are perceived as outliers, in the hope that public disclosure will effect desired changes in behavior. We work internally with physicians and hospitals using their own clinical data to effect desired and appropriate changes in provider behavior.

MEDICALLY MEANINGFUL DATA

While we are not opposed to the release of clinically reliable and medically meaningful data on hospitals and physicians in the public domain, our company only releases physician level clinical data to physicians, as our purpose is to engage physicians in a continuous quality improvement process. We do believe however, that there is medically meaningful information which would be useful to consumers.

We support for example, the efforts of my co-panelist Mr. Schneider, the editor of Health Pages. These efforts rely on information that is medically

meaningful and the one clinical indicator that is used, C-Section rates, is a clinical indicator that can be fairly displayed at the consumer level. The information is clinically reliable because the appropriate disclosures are made regarding physician case mix, in this case that the physicians treat high-risk pregnancies which would raise their C-section rates. Unless this information were included with the other data one might, inappropriately, surmise that physicians had an inordinately high rate of C-Sections.

Before I discuss the issue of clinical reliability, I would like to highlight a number of areas where I do believe that medically meaningful information would be helpful to be released into the public domain, including;

- Physician sanctions by a hospital medical staff
- Physician reprimands by a hospital medical staff
- Loss of a physician's hospital credentials
- Physician suspension from a medical staff
- Board certification
- Number of surgeries performed by a physician annually.

CLINICALLY RELIABLE

The second type of data, inpatient clinical outcomes data, is a key element of our business. We have specific concerns about the reliability, statistical validity and explanatory uses of clinical data released at the consumer level. Our concerns relate to the constant evolution in predictive validity and clinical reliability of inpatient severity measurement systems and the lack of

severity-adjusted, uniform, all payer hospital discharge data bases. These limitations make it difficult to track physician outcomes across facilities.

One of the key issues to address in any clinical information is the way that the information is analyzed: for instance is it severity and case mix adjusted and are an appropriate number of cases assessed to render clinical significance?

Even at the hospital level, it is extremely difficult to determine the reliability of clinical information unless you have an extremely large number of cases for a specific procedure that are analyzed over a significant period of time. Even at the hospital level it is difficult to draw clinically reliable and significant conclusions because the number of cases in a particular DRG or Major Diagnostic Categories (MDC), in a specific acuity index may be very small. Observations have shown for instance, that even in areas where we can look at a relatively large number of hospitals, the rate of infection may vary by only 2-4 percent, which may not be statistically significant nor clinically reliable.

Clinically reliable data at the physician level is even more problematic, as it is dependent upon a variety of factors some of which are in the physician's control and some of which are outside of the physician's control. Both clinical and structural inputs affect the outcomes of care for any given patient. To gain a true understanding of the clinical outcomes you must have a very large number of comparable cases from which you can perform a clinically reliable analysis. While this can be done with C-section rates -- if the case mix is disclosed and the information is severity adjusted -- it is generally difficult

to assure clinical reliability for other procedures at the individual physician level because of the relatively small number of cases which can be observed.

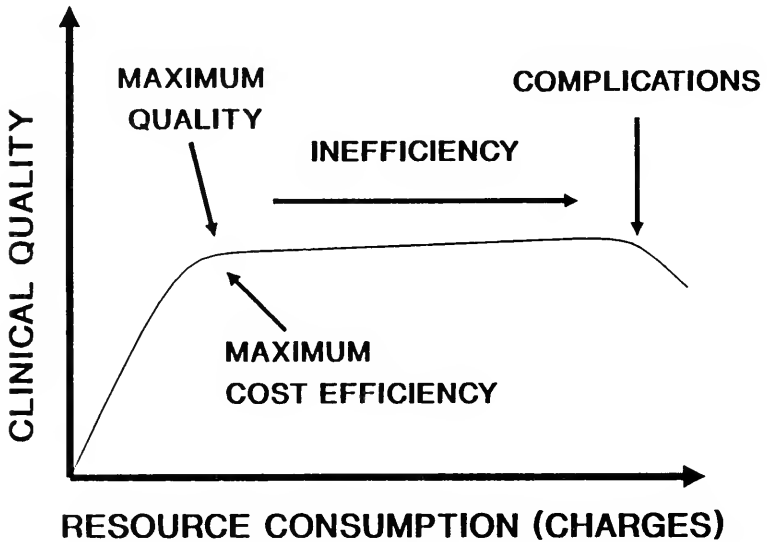
CONCLUSION

We support the collection, analysis and distribution of information which is medically meaningful and clinically reliable at the hospital and physician level. This has been Iameter's mission for more than ten years. However, we feel strongly that release of information in the public domain must first meet these two criteria and must be handled judiciously.

We must protect against the release of clinically unreliable data which may, unfairly, portray a provider as being responsible for an adverse outcome. In addition, we must ensure that both structure and process are taken into account, as the cause of an adverse patient outcome may or may not have been in the control of the individual provider. And lastly, we must ensure that data is not released in the public domain which does not accurately reflect or explain the possible causes for the variation or the outcome, i.e. it is not statistically significant or doesn't adjust for case mix or severity of illness.

We hope we can continue to offer our insights to you and the Committee as you proceed in this most important endeavor and hope that our comments today have shed some light on areas where caution and discretion must be exercised to ensure that any data that is published is in fact medically meaningful and clinically reliable. Thank you.

RELATIONSHIP BETWEEN CLINICAL QUALITY AND INPATIENT RESOURCE CONSUMPTION

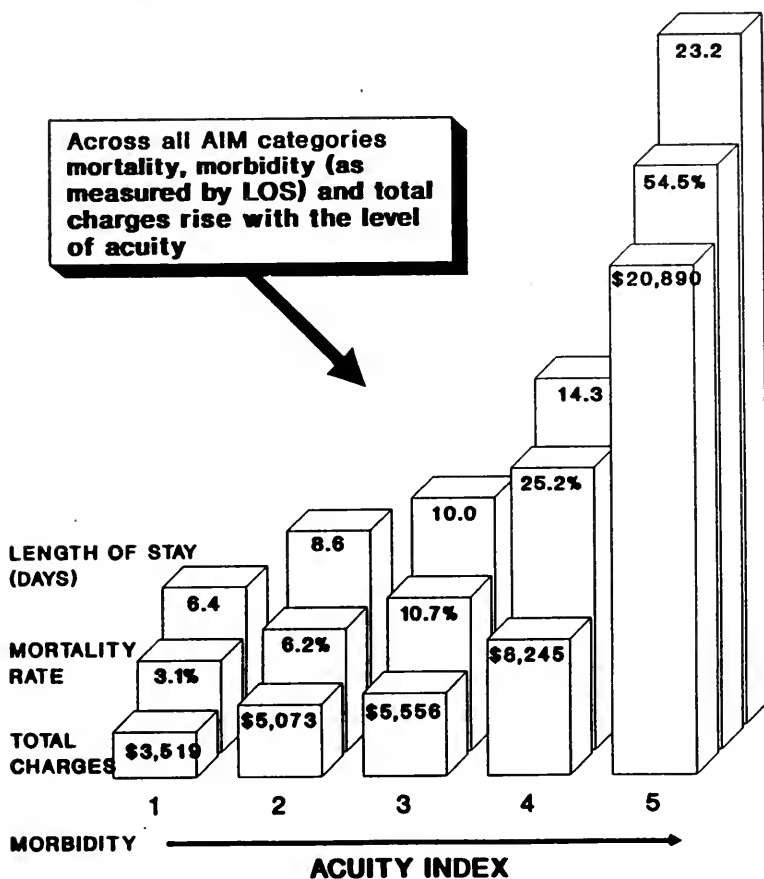


PHYSICIANS HAVE ONLY BEEN TAUGHT TO MAXIMIZE
CLINICAL QUALITY. NOW THEY MUST LEARN HOW
TO MAINTAIN HIGH QUALITY WHILE SIMULTANEOUSLY
MAXIMIZING COST EFFICIENCY

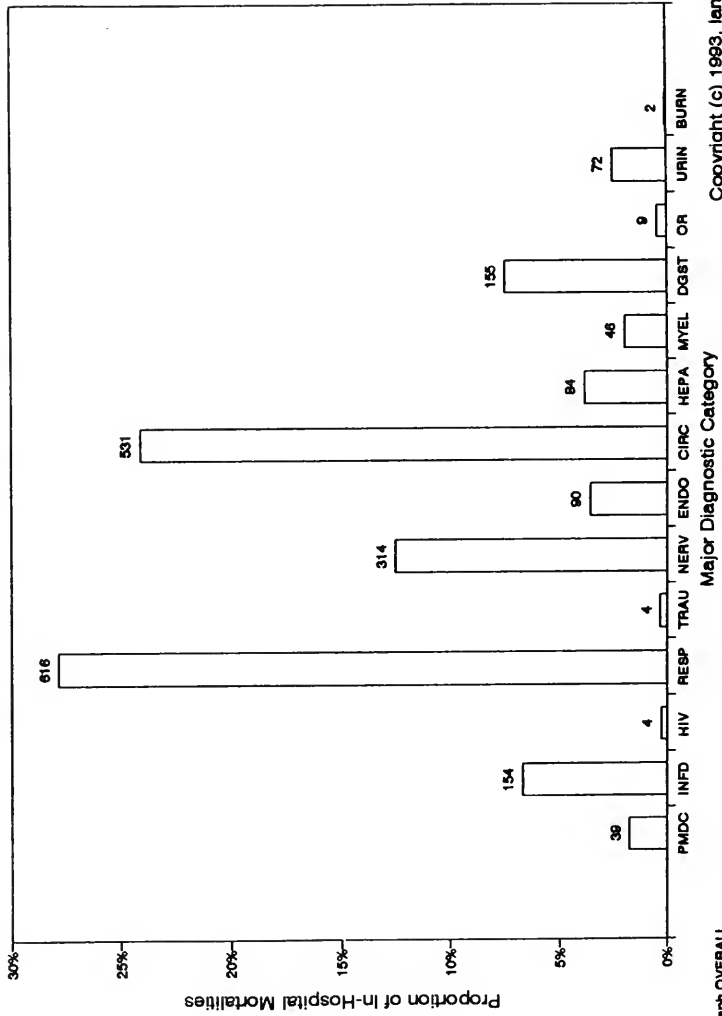
LOS, MORTALITY RATE AND CHARGES BY AIM CATEGORY

DRG 239 - PATHOLOGIC FRACTURES

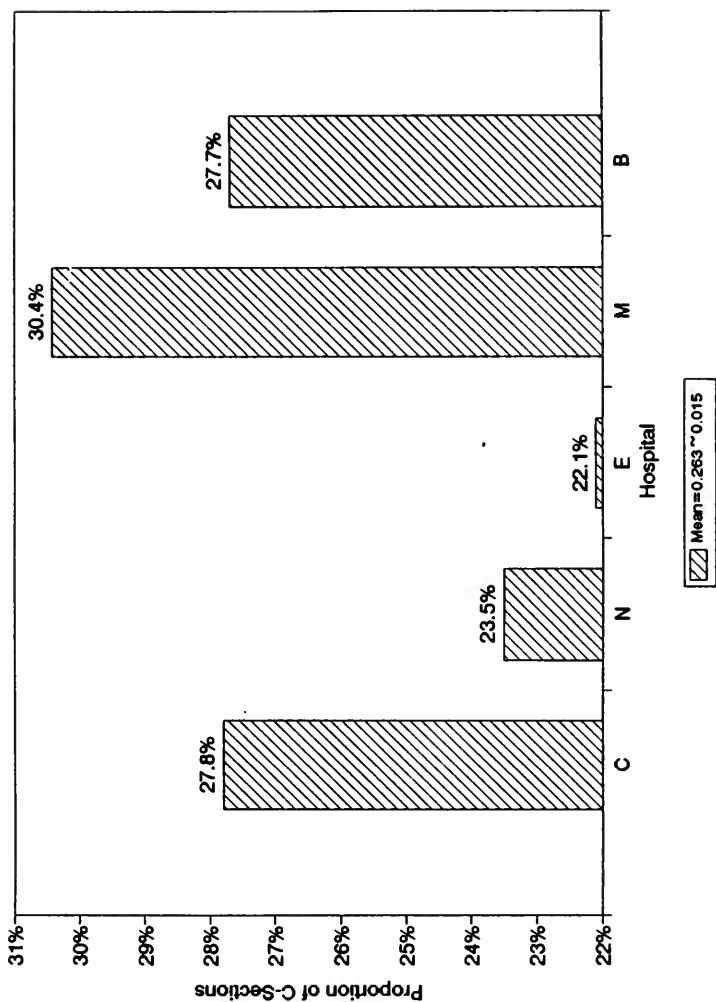
Across all AIM categories
mortality, morbidity (as
measured by LOS) and total
charges rise with the level
of acuity



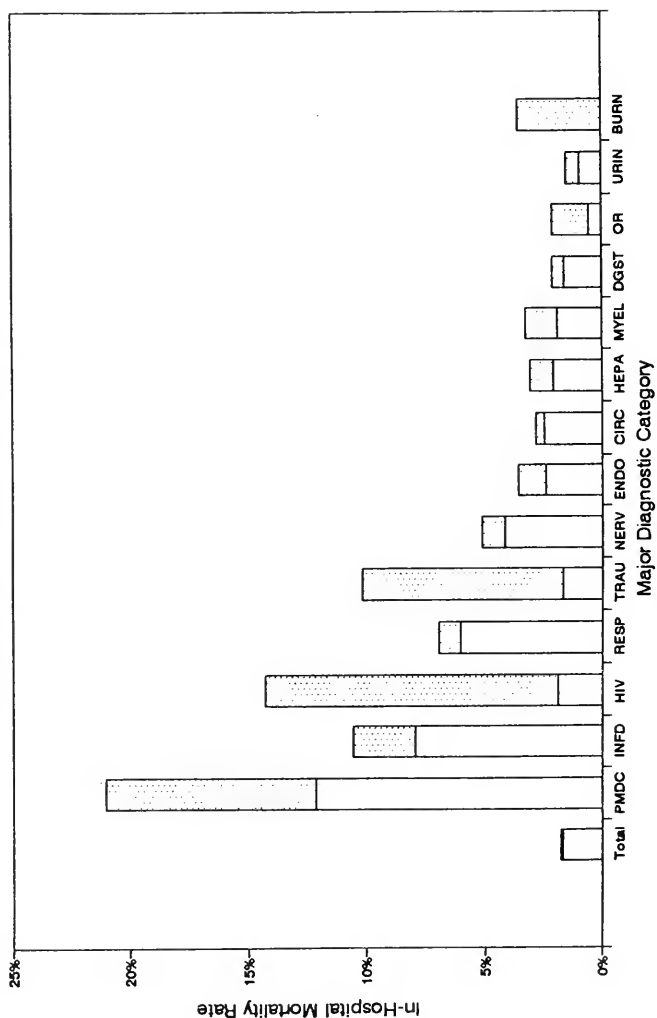
Mortalities by Selected MDCs in Southwest Selected Major Hospitals in Metro Region



Hospitals 1991
01: C-Section Rates



Mortality Rates by Selected MDCs in Southwest Selected Major Hospitals in Metro Region



*Pennsylvania's Declaration
of Health Care Information
A Commitment to
Quality, Affordable,
Health Care*



**PENNSYLVANIA HEALTH CARE
COST CONTAINMENT COUNCIL**

*Ernest J. Sessa
Executive Director*

TESTIMONY

OF

ERNEST J. SESSA

Executive Director

before the

House Subcommittee on Regulation, Business Opportunities and Energy

June 28, 1993

**Harrisburg Transportation Center Suite 2-F, Fourth & Chestnut Sts.
Harrisburg, PA 17101 717-232-6787**

According to former Surgeon General C. Everett Koop (in a letter to U.S. News and World Report), "The only way to determine improvement in hospital and physician performance is through repeated documentation made available to the public on a continuing basis. This public and professional examination of performance is necessary no matter which direction America takes in restructuring and refinancing its health care system."

According to a past survey by the American Hospital Association, over 35% of those who enter the hospital choose the hospital themselves. This is expected to rise to 50% over the next decade. Consumers and purchasers of health care, therefore, can greatly benefit from objective information about which hospitals and physicians provide the highest quality care in the most efficient manner.

Pennsylvania, through the ongoing support of our state legislature, Governor Robert Casey, and the business, labor, consumer, insurer, hospital and physician communities, is in the forefront of a national movement to contain health care costs. The Health Care Cost Containment Council (HC4) was created in 1986 to introduce market-driven competition into the health care delivery system. This independent state agency collects and distributes cost and quality related data for acute care hospitals in the Commonwealth.

Concerned about escalating health care costs, business and labor groups have worked together to provide the major thrust behind the council's creation and activity. Both recognize the health issue as a growing factor in labor-management conflict. Health care benefits are now seen as the number one cause of strikes in Pennsylvania.

In addition, employers, as major purchasers of health care for employees, will know which institutions provide cost-effective care, and make informed selections based on quality as well as price. This unique approach, choosing market competition over rate regulation, is being closely watched by other states.

The underlying concept is that like airlines that improve their on-time performance when ratings are published, health care providers will improve their performance when the facts become known. This will rein in costs and improve quality for everyone. In addition, consumers and major purchasers of health care, will know which institutions provide cost-effective, high quality care.

The Council's Hospital Effectiveness Reports detail the average amount that every acute care hospital in Pennsylvania has charged for the most common illness categories. And that information is combined with an accounting of each hospital's patient treatment results, so that consumers can measure quality as well as cost.

The Council's recently published Consumer Guide to Coronary Bypass Surgery, hailed by Dr. George Cimochoowski, chief of cardiac surgery at Wilkes-Barre General Hospital, as a "sophisticated analysis," provides to the public risk-adjusted mortality rates for hospitals, practice groups, and surgeons who performed at least 30 bypasses in 1990. The report, which covers 15,000 operations, also shows that the hospitals' average charges for the procedure varied from \$21,063 to \$83,851. No other state in the country has done that. To date, the Council has filled over 10,000 requests for this report.

This kind of data is helping increasing numbers of consumers, as well as other purchasers of health care such as businesses, health and welfare funds, and insurers, make comparisons, identify the most efficient and effective hospitals and doctors, and make more informed health care decisions.

Although critical to any approach, the data the Council currently provides, plus the potential data it could provide given appropriate resources, can play an important role in a managed care strategy. However, I strongly believe that this kind of information also offers a tremendous strategic opportunity to deal with the "hard choices" it is speculated that we will have to make in order to reform the health

care system. That opportunity is to focus on not simply the cost issue, but the quality issue as well, in an aggressive way..

We've spent 10 years and billions of dollars on the "managed" part of managed care. But have we looked enough at how "care" is rendered? I believe that the answer is no.

The human cost of poor quality care is staggering. Let me give a few examples.

The Rand Institute reports that up to one-third of carotid endarterectomies were unnecessary. Rand also found that only 56% of coronary bypass operations were justified.

The Blue Cross\Blue Shield Association estimates that 27% of tonsillectomies and 22% of hysterectomies were inappropriate.

A 1991 Harvard University study calculated that 7,000 people died in New York hospitals from medical negligence in one year. That suggests that as many as 80,000 people nationwide may be dying annually from negligence.

And bad care also costs a lot of money. Misdiagnosis, substandard surgery, improper drug therapies, and hospital-acquired infections result in more and longer hospitalizations.

In our recent Consumer Guide to Coronary Bypass Surgery, we reported that approximately 15,000 bypass operations were performed in the Commonwealth in 1990. These operations were then risk-adjusted to account for the age, gender, and medical condition of each doctor's and hospital's patients. In other words, like divers who receive extra credit for the difficulty of dives they attempt, the Council's reports adjust the data so that doctors who take high-risk patients are not unfairly compared to those who don't.

The average charge in PA was \$46,000 per bypass. That's a total of \$690 million in charges. Allegheny General Hospital in Pittsburgh, a highly-regarded, a major metropolitan heart institute, charged \$46,000 and was one of only four hospitals in Pennsylvania with fewer than average, risk-adjusted patient deaths - a superior performance. If all hospitals who charged more than the average of \$46,000 reduced their charges to Allegheny General's level, the savings would amount to about \$88 million each year, just for bypass surgery. Or apply the Rand figure of 44% unjustified bypass operations to Pennsylvania - and I want to stress that I'm speaking hypothetically because we don't know if this holds true for Pennsylvania. But I want to use Pennsylvania as an example and the point I want to make is that if the Rand figures were appropriate to Pennsylvania, according to the 1990 figure approximately 7,000 procedures might have been unnecessary, or could have been treated in a less expensive more appropriate way.

This is not a far-fetched example. Last year, St. Vincent's Hospital in Erie announced a \$5 million annual reduction in their open heart surgery charges. St. Vincent's acknowledged that the reason was to compete with nearby Hamot Medical Center, shown to be less expensive in the Council's public Hospital Effectiveness Reports. Competition can reduce costs.

Our report also seemed to underscore the idea - which is no mystery to contemporary management experts - which is the principle that quality costs less. The lowest cost hospital in Pennsylvania charged \$21,000 per bypass and had better than average mortality rates, while the highest priced hospital charged \$84,000 and had worse than average mortality rates. These two hospitals were placed on the same level playing field due to the Council's extensive adjustments for the condition, age and gender of each patient.

Instead of "micromanaging" the process - contracting with providers based solely on their preferred pricing schedule rather than on their quality of care - insurers and employers need to consider the outcomes of patients and the price tag of poor provider results. The Council could provide this information.

According to Allan Korn, M.D., a principal with William M. Mercer, Inc. in Chicago, quoted in the National Underwriter (9-7-92) "Typically, providers with high mortality rates (on a risk-adjusted basis) tend to be more costly than those with better mortality, because they generally end up dealing with more patient complications and deaths."

Korn went on to claim that some 13% of the outpatient dollars billed by preferred provider organizations are deemed to be flagrantly unnecessary. He went on to say that "since outpatient care comprises 60% of the \$700 to \$800 billion spent on health care, the impact of unnecessary care becomes clear. Could that 13% care for 37 million uninsured? "Sure it could," said Dr. Korn.

Payers will never be able to truly eliminate those unnecessary procedures via utilization review since it is impossible to monitor every office visit. So, how can you get at unnecessary costs? Direct patients to hospitals and doctors based on quality, not just cost.

Another criticism of managed care is that patient care will be rationed. But focusing on quality can help us to avoid rationing. Rationing is avoiding care that is medically necessary. Discipline is avoiding care that is not medically necessary. That's what high quality hospitals and doctors do.

Another major public concern is that patients will lose their ability to choose under a managed care system. But focusing on quality can help to alleviate this concern. Under a managed care system which focusses on identifying and creating provider networks of high quality, cost-effective physicians and hospitals, one could take the approach that the only choice that will be restricted is the ability to choose a high cost, poor-quality provider. This can enable us to surmount a major political hurdle. Convincing the public that managed care doesn't mean cheaper, but substandard, care is a key to the success of the system. Self-insured companies, the government, HMOs, or as proposed under managed competition, sponsoring organizations which purchase care for consumers, need cost and quality data in order to reassure people that they are in fact getting the best care at the best price.

The New York Times writes that under managed competition, sponsoring organizations would have the knowledge and leverage to drive hard bargains with insurers. Sponsors would make comparison shopping easy. HMOs could concentrate specialties - heart surgery in one hospital, prostate surgery in another. HMOs could match the number of urologists, radiologists and other specialists to need, a source of tremendous savings. HMOs could systematically study, therefore improve, treatment practices and outcomes. The sponsors would be able to enforce high quality and low prices. Sound information such as the Council is providing and has the potential to provide must be available for them to do any of these things.

Managed competition has had results. In California, nearly one million state employees are enrolled in a managed competition system. While premiums soared elsewhere, the HMOs which do business with the state of California maintained present premiums or even reduced their premiums. In Minnesota, the state had saved more than \$20 million as of a year ago, since it embraced managed competition in 1989. And that was without true quality measurements which they are now moving into. The Xerox corporation, with its managed competition strategy, estimates a savings of \$1,000 per employee per year for those enrolled in an HMO rather than an indemnity plan. As of 3/92, Xerox had achieved 65% enrollment. Their goal is 80% by 1995.

Getting at the quality issue means arming patients and purchasers with credible data which they can use to make informed comparisons, identify value, and choose the high quality, cost-effective doctors and hospitals. That's where this kind of information comes in.

Focusing on quality gives patients a real choice. There is a legitimate concern over patient choice. But patients now have only limited, generally anecdotal information upon which to base a choice. However, there is a growing movement in states like Pennsylvania and Iowa, in cities like Cleveland and St. Louis, to give consumers and purchasers objective, risk-adjusted data to use in identifying the most efficient, effective providers.

The public's anxiety rests on the belief - correct or not - that managed care organizations care only for the bottom line, and that quality will be sacrificed on the altar of cost containment. If, under managed competition, managed care networks must compete on quality as well as price criteria, purchasing groups can reassure consumers that the quality of medical care is key. Patient choice - a more informed choice - can be maintained.

Focusing on quality can eliminate the trend towards micromanagement of medicine. Instead of second-guessing doctors after the fact, businesses, insurers, other purchasers, and consumers can use quality measurements to select the best providers up front, and then let them do their jobs. There is less pressure to second-guess procedures and treatment, less need to examine every action.

Focusing on quality may help us elude the difficult choices of rationing. Eliminating unnecessary procedures and treatments, reducing overutilization, rewarding quality and cost-efficiency can free up enormous resources to provide care for all. Rationing is not providing essential medical care. High quality doctors and hospitals avoid care which is not medically essential.

Americans have more information about which is the best car to buy than which is the best hospital or doctor to go to. Let's focus on the quality issue; it makes everyone a winner.



Publisher of Consumer Reports

Testimony of

GAIL SHEARER

MANAGER, POLICY ANALYSIS

CONSUMERS UNION

before the

SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES AND ENERGY

SMALL BUSINESS COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

June 28, 1993

HEARING ON

INFORMED CONSENT: THE ROLE OF CONSUMER CHOICE

IN IMPROVING THE QUALITY OF HEALTH CARE

Mr. Chairman and Members of the Subcommittee, Consumers Union¹ appreciates the opportunity to present our views on important consumer issues relating to health care reform. We commend you for your leadership on the issue of consumer protection in health care. Like you, we eagerly await the announcement of the Clinton Administration's health care reform proposal, and look forward to its consideration by the Congress.

The main issue that this testimony addresses is consumer preferences with regard to freedom to choose their own doctor. Before summarizing key findings on this issue from a recent Consumers Union/Gallup survey, I would like to outline the five principles that Consumers Union supports as the key elements of health care reform. These are components that we will look for in the Administration's forthcoming health care proposal and in future Congressional proposals.

To meet the needs of consumers, any health care reform plan must offer:

universal, quality health care (with comprehensive benefits) for all U.S. residents -- regardless of age, income, employment

¹Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

status or health status;

cost containment with a national health care budget and control over wasteful paperwork and procedures;

fair-share financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;

public accountability with consumers well represented on all boards overseeing health care; and

consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

On April 20, 1993, Consumers Union released results of a survey that explored consumer preferences on health care issues, with several questions that explored views on consumer choice of doctor in detail. The results are summarized in the next section.

CONSUMERS UNION/GALLUP POLL:

CONSUMERS VALUE FREEDOM TO CHOOSE THEIR DOCTOR

The survey was conducted for Consumers Union by the Gallup Organization on March 26 through April 9. 1006 heads of households were asked a number of questions about viewpoint on various health issues. The findings about preferences on choice of doctor were dramatic and show very clearly that most Americans care deeply about choice of doctor. They want the freedom to choose their own doctor when they are healthy, and they want access to the best medical care when they are sick. The survey found:

- **85 percent of consumers responded that choice of doctor is very important or somewhat important; they want the**

option to choose a doctor on their own rather than selecting one from a list provided by a health plan. Consumer preference for ability to choose their doctor was consistently high among people with traditional health insurance and across different income groups.

- **Americans want to choose their specialists.** When illness strikes, people want the freedom to choose the specialist they think can provide the best care. More than nine out of ten Americans polled (91 percent) said it is very important or somewhat important to select a specialist without being restricted to a list provided by a health plan. People in health maintenance organizations are less likely to have freedom to choose specialists; nearly half of all people in HMOs (47 percent) are not given free choice of specialists.
- **People are willing to pay more for health care if they can choose their doctors and specialized medical care centers.** Fully 43 percent of people surveyed with and without family health-care coverage are willing to pay \$25 or more per month -- \$300 per year -- to preserve the right to select a physician. 51 percent indicated that they are willing to pay this amount to ensure access to treatment at any high quality specialized medical care center.
- **Freedom of choice is important to low-income families.** Even though their pocketbooks may be strained, 41 percent

of families earning less than \$25,000 a year are willing to pay \$300 a year or more in additional taxes for health care if they are able to pick their physicians.

- **People care about choosing a doctor, not about which insurance company covers them.** Consumer choice means more than shopping around for a health plan -- it means freedom to choose a doctor. 73 percent of Americans polled said they care more about choice of doctor than choice of insurance company.
- **Some Americans are being forced to switch doctors.** One out of 12 Americans surveyed (8 percent) have had to change doctors in the past two years due to restrictions imposed by their health-care plans. They were three times more likely to have to make a switch if they are in an HMO than in a traditional health-care plan.
- **Even people who are enrolled in health maintenance organizations (HMO's) and preferred provider organizations (PPO's), insurance plans that typically restrict freedom of choice of doctor, value freedom to choose their doctor.** 78 percent of people enrolled in HMO's responded that freedom of choice of doctor is very important or somewhat important to them, compared with 81 percent of those enrolled in PPO's and 91 percent of those that are covered by a traditional insurance policy. (See attached figure).

IMPLICATIONS FOR HEALTH CARE REFORM

The strength of consumer feelings about the importance of freedom to select primary care doctors, specialists, and specialized medical care centers has important implications for national health care reform. Any health reform proposal that fails to recognize that consumers want to choose their doctor -- not their insurance plan -- will never gain the public support needed for enactment of comprehensive reform. Consumers Union has supported a single-payer health care system as the best way to assure consumer choice of doctor objectives and satisfy the other consumer goals for reform. Our comments below address the doctor choice issue in the context of the managed competition type of proposal that is under consideration by the Administration.

Consumer choice of doctor matters to consumers because doctors' skills vary and consumers want access to the highest quality care. Consumers need full -- and understandable -- information before they enroll in a health plan -- about the qualifications of primary care doctors if the health plan limits the selection of primary care providers.² For each health plan, consumers need to know the percentage of the plan's physicians that are board-certified, information about malpractice and other

²Many of the suggestions in this section could be incorporated into a health plan's "report card." A full discussion of the information that should be included in report cards is beyond the scope of this testimony. Key measures that should be included are: results of a standard enrollee-satisfaction survey; disenrollment rates; ability to choose doctors/specialized care centers outside of the plan; hospital mortality data for specific procedures; complaint statistics; immunization rates.

disciplinary actions, the percentage of the plan's physicians that are U.S. medical school graduates, and the extent of provider turnover at the plan. To facilitate selection of a primary care doctor, consumers should have access to information about any doctor's board certification, educational background, number of years with the plan and previous experiences, teaching responsibilities, type of physician specialty, patient load and current availability, usual wait for a non-emergency appointment, admitting hospitals' special awards and honors, and number and resolution of medical malpractice cases.

Consumers need to be able to make an informed choice of doctors. We enthusiastically support the Chairman's efforts to enhance the effectiveness of the National Practitioner Data Bank by allowing the public access to the information concerning the professional competence of physicians. We were appalled that the American Medical Association (AMA) recently called for its abolition. Consumers Union is committed to broadening the scope of the Health Care Quality Improvement Act of 1986 (P.L. 99-660) so that not only will the public continue to enjoy a choice of doctors but it will have a meaningful choice as well.

Special protections are needed if a health plan limits choice of specialist or access to specialized medical centers. Choice of primary care doctor for healthy consumers raises one set of issues about needed information. A more challenging public policy problem is posed **once a family is enrolled in a health care plan and serious illness strikes.** It is clear from our survey that this

fear of limited choice once illness strikes is on people's minds. When medical treatment can make the difference between life and death, consumers want to know that they can have access to the best care for their families and themselves. The prospect of seriously ill consumers being locked-in to second-rate care -- based on a choice they made when they were healthy -- raises troubling issues. One modest protection that should be built-in to health reform would be full disclosure to consumers of the extent to which plans limit access to specialists and access to specialized medical care centers such as the Mayo Clinic. Another protection that should be considered is building in some flexibility, with the possibility (fully disclosed of course) that should serious illness strike, consumers could have access to specialized centers or specialists outside the plan, for a modest increase in cost-sharing (or premiums).³

Under a managed competition framework, there could be a tradeoff between free choice of doctor and cost savings. However, cost savings should not be achieved at the expense of intense consumer dissatisfaction. Other cost savings mechanisms including cutting administrative waste, eliminating unnecessary procedures, and global budgets are needed. A recent study shows that staff-model and group-model HMO's -- that pay doctors on salaries or on a capitation basis -- are most effective at achieving cost savings. These are the very type of HMO's that limit consumer choice of

³Analysis of the implications of this policy for people who can not afford this extra cost should be conducted.

doctor most. To achieve these savings, "[l]imitations could be placed on people's existing choice of providers, health insurance coverage, and treatment alternatives; also, access to new technologies might be restricted or permitted only after a longer waiting time. In other words, managed care, when effective, does impose constraints on patients and providers."⁴ In order to achieve health reform that has broad public support, it is crucial that the Administration and Congress seek savings from cutting administrative waste, eliminating unnecessary procedures (with the development of outcomes research), and enforceable global budgeting. The wrong way to achieve cost savings is to limit consumers' choice of doctors. Not only do consumers perceive that this could lead to inferior care, but in reality this could indeed be the case.

As bad as a one-time need to change primary care doctors could be, it is crucial that health reform not require consumers to make regular (even annual) changes in providers. Some analysts argue that a transition to a new health care system would not deprive consumers of their physicians -- consumers can simply follow their doctor to an HMO. While this might hold true for a single person with one family doctor, it does not hold true for families that could have a pediatrician, internist, gynecologist/obstetrician, dermatologist, cardiologist, and assortment of other specialists.

⁴Verdon Staines, principal analyst, Human Resources and Community Development Division, Congressional Budget Office, "Potential Impact of Managed Care on National Health Spending," Health Affairs, Supplement 1993, pp. 248-257.

Even a one-time requirement to switch this full array of doctors would be burdensome. Of even greater concern, however, would be this scenario that is entirely possible under some managed competition proposals: each year a Health Alliance could select a different plan (or two) as the "benchmark" plan. If the benchmark plan changes away from the plan the family had selected, the family may no longer be able to afford to stay in their plan, and might be forced (for financial reasons, such as less subsidy or less tax deduction) to change to another plan. Continuity of health care is one important component of a quality health care system, and this concern should be addressed in shaping the plan.

Low income consumers care deeply about freedom to choose their doctors; low income consumers should have the same range of health care options that high income consumers have, to avoid a multi-tier health care system. Some managed competition proposals would encourage price competition among health plans, and raise the prospect that higher income families and individuals would buy their way into traditional fee-for-service health plans, while low income families would essentially be dumped into bare-bones managed care plans with a minimum of coverage and quality. The Administration has been sensitive to this concern by discussing a standard comprehensive benefit package and by considering various options that would prevent the development of a multi-tier health care system. Our survey showed clearly that low income consumers value freedom to choose doctors very strongly -- though they are less able to pay for this freedom. It is crucial that the question

of how best to avoid a multi-tier/multi-quality health care system be given full consideration by both the Administration and the Congress.

OTHER FINDINGS OF THE CONSUMERS UNION/GALLUP SURVEY

Our survey explored issues besides consumer freedom to choose their doctor, and the results are summarized below:

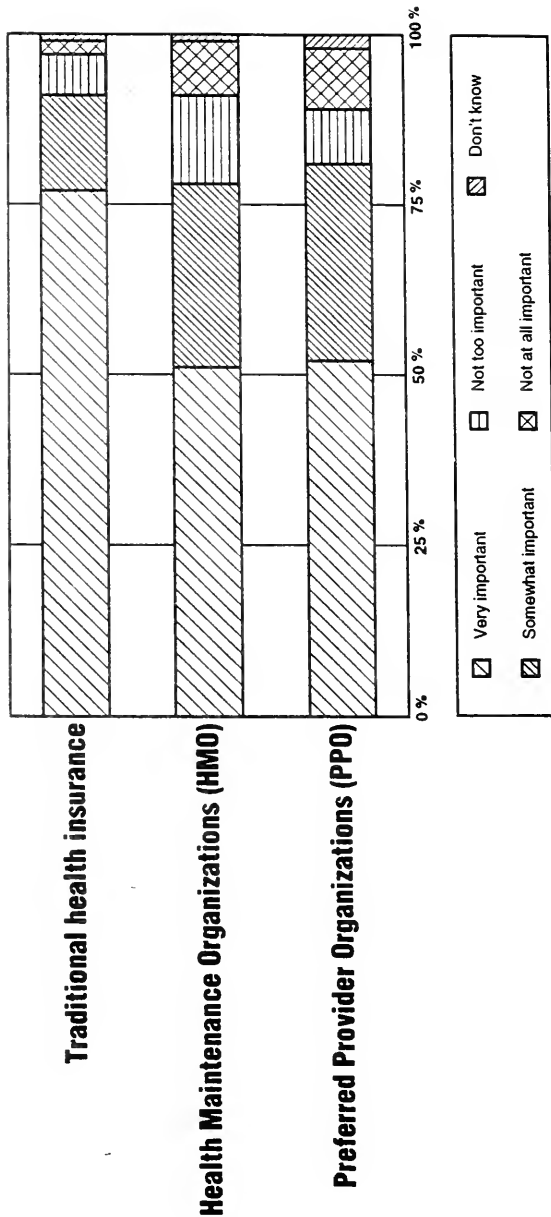
- More than 8 in 10 of those surveyed support the creation of a health-care plan that covers everyone.
- Three out of four are willing to pay higher taxes to help support a national health care plan. Based on these findings, Consumers Union projects American consumers would pay \$37 billion more each year in taxes so that everyone is covered.
- Middle-income respondents support universal health-care coverage, even if it means paying more taxes. Specifically, 64 percent are willing to pay an additional \$240 or more in taxes each year if the money would go toward funding a comprehensive health care plan for everyone.
- Even those with higher incomes (67 percent) are willing to pay that amount in taxes to ensure universal coverage.
- Virtually all of those polled favor universal access to a comprehensive health plan that includes: doctor care, hospitalization, prescription drugs, well-child visits and immunizations, nursing home care, long-term care at home, mental health treatment, dental care, prenatal

care, and vision coverage.

- Nearly nine out of 10 agrees with the statement: "Losing your job should not force you to change or lose health insurance."
- Fear of losing health insurance has kept one out of five from accepting a job offer or looking for a new job.
- 14 percent have accepted a job mainly for the health insurance.
- One out of three fears not having enough money to pay for a major illness or operation. Even people with insurance are uneasy: Even 25 percent with health insurance are worried about their ability to pay for a serious illness.
- Nine out of 10 support including long-term care in the benefits package. Support for long-term care goes beyond older Americans. Fully 91 percent of 18 to 44-year-olds favor providing long-term care.

Thank you for providing Consumers Union with this opportunity to present these findings to the Subcommittee about consumer support for key elements of national health care reform. We look forward to working with this Subcommittee as the debate about national health care reform continues.

How Important Is Freedom Of Choice?



You know there's a crisis in health care because:

- Some 35 million Americans have no health insurance coverage
- An additional 60 million people are underinsured
- Each year 1 million families try to obtain care when they are sick but find they cannot afford it
- Today only a minority of Blue Cross and Blue Shield plans still make policies available to everyone
- The United States spends some 14 percent of its GNP on health care—no other industrialized country spends more than 10 percent.
- Of the 24 industrialized nations that form the Organization for Economic Cooperation and Development, the United States ranks 21st in infant mortality, 17th in male life expectancy, and 16th in female life expectancy

How You Can Help Resolve the Health-Care Crisis

If you agree that Americans deserve a solution to the national health-care crisis that provides universal, quality care; cost containment; fair-share financing; public accountability; and consumer choice, here's what you can do right away:

1. Contact the President and members of Congress to let them know where you stand.
 - ✍ Write to President Bill Clinton, The White House, Washington, D.C. 20500.
 - ✍ Write to your congressman in the U.S. House of Representatives. The address is: U.S. House of Representatives, Washington, DC 20515.
 - ✍ Write to your two Senators. The address is: U.S. Senate, Washington, DC 20510.
 - ✍ Send a copy of your letters to: Program for Economic Justice, Consumers Union, 101 Truman Avenue, Yonkers, NY 10703-1057.
 - ✍ Call both Senators and Representatives at: (202) 224-3121.
2. Contact your governor and state legislators.
 - ✍ Write letters to your governor and state legislators supporting the five principles. If you don't know where to write, contact your county election bureau, your local public library, or the League of Women Voters.
3. Stay informed.
 - ✍ Read newspaper and magazine articles about health-care issues. Contact local, state and national organizations that are working to reform the health-care system.
 - ✍ Be skeptical about who you read or hear. Be aware that powerful insurance and health-care provider groups are spending lots of money on propaganda to influence your views.



HEALTH CARE IN CRISIS:

Building a System that Works for Consumers

Printed on recycled paper

- ✍ Work with others to blow the whistle on misinformation about health-care reform. Contact the organizations listed below.
- 4. Talk back to the news media.
 - ✍ Write a letter to the editor of your local newspaper saying that you support the five principles listed inside. Give reasons and facts supporting your position.
 - ✍ Call radio talk shows to express your views.

5. Join organizations working for universal access to health care.

To obtain further information about who supports single payer health insurance in Congress and the state legislatures, write to the organizations listed below. Ask if there's a state or local organization near you that can use your volunteer help.

National Organizations:

Fund for Health Security
1120 19th Street NW, Suite 630A
Washington, DC 20036

Action for Universal Health Care
c/o Northeast Ohio Coalition for
National Health Care
1800 Euclid Avenue, Suite 318
Cleveland, OH 44115

In Texas and New Mexico, contact:

Consumers Union
Southwest Regional Office
1300 Guadalupe, Suite 100
Austin, TX 78701

Consumers Union
West Coast Regional Office
1535 Mission Street
San Francisco, CA 94103

Resources available at bulk rates (for quantities of 10 or more) from Consumers Union, publisher of CONSUMER REPORTS:

- ✍ A 270-page paperback book: "How to Resolve the Health Care Crisis: Affordable Protection for All Americans." Contact Consumer Reports Books, (914) 378-2630.
- ✍ Reprints of CONSUMER REPORTS' 3-part series on "Health Care in Crisis" (Part 1: "Wasted Health-Care Dollars"; Part 2: "Is Managed Care the Answer?"; Part 3: "The Search for Solutions"). Contact Consumers Union Reprints & Permissions, (914) 378-2448.

Consumers Union

Publisher of Consumer Reports

101 Truman Avenue
Yonkers, New York, 10703-1057

CONSUMERS UNION'S WORK ON HEALTH-CARE POLICY

Support for universal, quality health care has been a tradition at Consumers Union since its founding in the mid-1930s. Our publication, CONSUMER REPORTS, has regularly covered issues concerning health-care policy, reporting on developments involving the medical community, the insurance industry, the government, and most importantly, the consumer.

In 1937, CONSUMER REPORTS told the public of efforts to achieve a "national health policy directed toward all groups of the population." In the early 1940s, Consumers Union advocated group health plans, which CONSUMER REPORTS referred to as "one way to give the consumer the medical care he deserves at prices he can afford."

In the late 1940s, Consumers Union supported the Wagner-Murray-Dingell Bill, which would have provided medical care for everyone in the U.S. In 1950, CONSUMER REPORTS told of the American Medical Association's two-decade-long public relations campaign against national health insurance, which included more than a million dollars worth of advertising on radio and in newspapers and magazines.

While well-financed lobbying by special interests kept national health insurance off the Congressional agenda in the 1950s, our present health-care system took shape—a system mired in private bureaucracy, waste, and doubtful health outcomes, in which tens of millions are left without adequate health care. Over this span,

CONSUMER REPORTS has kept the public informed of developments in health care and insurance, reporting on group medicine, health-maintenance organizations, doctors' and hospitals' services, medical malpractice, Medicare, and long-term care insurance.

In 1990, CONSUMER REPORTS pointed out, "The system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care." And in September 1992, the magazine called for a single-payer solution to the health-care crisis, in which the best of the Canadian model of universal care would be adapted to U.S. needs.

The three advocacy offices of Consumers Union work to support a single-payer legislative solution to the nation's health-care crisis. Located in Austin, San Francisco, and Washington, D.C., the advocacy staffs testify before Congress and state legislatures, presenting the Consumers Union viewpoint to those working on health-care policy.

To meet the needs of consumers, any health-care reform plan must offer:

- UNIVERSAL, QUALITY HEALTH CARE for all U.S. residents—regardless of age, income, employment status or health status
- COST CONTAINMENT with a national health-care budget and control over wasteful paperwork and procedures
- FAIR-SHARE FINANCING with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis
- PUBLIC ACCOUNTABILITY with consumers well represented on all boards overseeing health care
- CONSUMER CHOICE giving consumers the freedom to choose where they will go for health care and who will provide it



Health-care reform has moved rapidly to the top of our government's action agenda. For many consumers—perhaps even you or someone you love—it isn't a moment too soon that's why we're asking you to get involved, as a citizen, in how this crisis is resolved.

Last year, CONSUMER REPORTS magazine published a three-part series detailing the widespread waste and abuse in our current health-care system. We wanted you to know.

- How the present system works
- Why health-care costs keep rising and how they can be controlled in a fair and effective way
- What health-care options are now available to consumers, and what we could expect from an improved health-care system

By covering this topic, we provided consumers with information to help make sense of the nation's health-care crisis. Now we are asking you to take an active part.

Consumers Union believes citizen participation—your participation—is needed to develop the best health-care system for our country. We want you to be heard at the local, state and federal level about your family's health-care needs, and how you believe they should be met.

It's no secret that insurance companies and the health industry feel threatened by health-care reform, and are spending large sums to assure their views will prevail.

Your elected representatives must hear from you so that health-care reforms serve consumer interests, not the interests of insurance companies, hospitals, and medical providers.

It's time for legislators to stand up for consumers on this issue. President Clinton has promised reform proposals within the first 100 days of his Administration. The enclosed packet contains Consumers Union's analysis and viewpoint on health-care reform. We encourage you to use the information in this brochure to let your legislators know how you feel.

Consumers must act now to make their voices heard.

Rhoda H. Karpaluk

Rhoda H. Karpaluk
President
Consumers Union

National Committee to
Preserve Social Security
and Medicare



Statement of

Bente E. Cooney
Chair, Workgroup on Consumer Information of the
Coalition for Consumer Protection and Quality in
Health Care Reform

Before

Committee on Small Business
Subcommittee on Regulation,
Business Opportunities and Technology

Regarding

Informed Consent: the Role of
Consumer Choice in Improving the
Quality of Health Care

June 28, 1993

Mr. Chairman, members of the Committee, I am Bente Cooney, Senior Policy Analyst with the National Committee to Preserve Social Security and Medicare. Today, I am here to testify as chair of the Workgroup on Consumer Information for the Coalition for Consumer Protection and Quality in Health Care Reform.

The consumer coalition consists of more than 30 member and supporting organizations. It was started earlier this year and has grown rapidly over the past few months. Consumers are concerned lest health care reform's focus on costs—capping, reducing and managing the cost of a new health care system—overshadow the critical need for quality assurance and consumer protection.

Consumer information is important in any health care system, but it is especially essential in a health care system based on the theory of managed competition. The concept assumes consumers will stimulate high quality and low costs through their choices of health care plans and providers. Consumer information is a potentially powerful tool that could give consumers increased control over their own health care. However, consumer choices will be only as good as the data provided.

Quality of Information

Consumer information should be managed by entities independent of the health plans and the health alliances. A national entity such as a National Health Board should be responsible for 1) establishing uniform data formats, 2) setting standards for collecting and analyzing data and 3) determining how the data should be distributed on the national, state and plan levels. It is essential that the data and information be accurate, reliable, comparable, timely, and easy-to-understand. It must also be available in different languages and formats for people with special challenges such as the visually impaired.

We want to make it clear, however, that even good consumer information will not eliminate the need for appropriate grievance and appeals procedures, internal and external quality assurance, and external, independent oversight and monitoring of the health care system.

Consumer Guide

We believe that consumer information must be more than a "report card." Perhaps a better description would be a "Consumer Guide" for plan selection and use.

There are probably hundreds of ways to present information to consumers, but at this point we envision four main categories of information:

- 1) plan-specific descriptions
- 2) plan-specific quality report cards including enrollee surveys
- 3) provider and practitioner-specific descriptions
- 4) condition-specific provider and practitioner quality report cards including enrollee surveys

The first two categories, plan-specific descriptions and plan-specific report cards, would be primary elements of the consumer guide, while the third and fourth categories, provider and practitioner-specific descriptions and condition-specific provider and practitioner report cards, would be available on request. I refer you to the attached draft white paper on Minimum Requirements for Consumer Information, which is being developed by the coalition for a more detailed discussion of these categories. We would appreciate it being included in the record.

1) Plan-Specific Descriptions

If consumers are going to make informed choices, they need good understandable information describing plan configurations, how the health care delivery system works, how to use the consumer guide, how to appeal a health care decision, how to resolve complaints, and how to contact a health ombuds- or counseling program. Next, they will need to know premiums and other out-of-pocket costs, and the benefits and services of each plan option. The goal is to enable the consumer to compare health care plans in a given health alliance. The information should include descriptive, practical and operational summaries presented in an easy-to-read, comparative format. Examples in this category would be:

- out-of-pocket costs
- cost of using services outside the plan
- policy on using services outside the plan
- benefits covered
- service locations
- rate of board-certified physicians

2) **Plan-Specific Quality Report Cards including Enrollee Surveys**

The center piece of the consumer guide should be a "report card" comparing plans based on quality indicators and results of enrollee surveys indicating satisfaction rates among current users. When appropriate, national averages should be provided for comparison.

Areas that should be covered include performance measures such as percent of enrollees who have received preventive care, such as:

- annual physicals
- immunizations and boosters for children
- flu shots for seniors

Also the report card should list indicators of undesired occurrences, such as:

- inappropriate use of medication
- re-admissions within 30 days of post-surgery hospital discharge
- hospital acquired infections

A standard survey should be developed to measure satisfaction among health plan participants. It could have some regional, individualized characteristics, but the main body of the survey should be consistent across the country so that it can be used for national comparisons.

The survey should be short and clear and contain questions related to acceptability, availability and accessibility, such as:

- overall satisfaction with care received
- convenience of location of doctors and hospitals
- excessive paperwork or bureaucratic hassles
- length of time spent in the waiting room
- length of time spent with the practitioner
- degree to which questions were answered

Also information about disenrollment and the number of enrollee complaints would be an indication of satisfaction/dissatisfaction with the plan.

3) Provider and Practitioner-Specific Descriptive Information

Further details on plans and their health care professionals should be provided on a per-request-basis either from the plans themselves or from the health alliance. For example, if a consumer is trying to decide between Plan A and Plan B, he or she may want to review a more detailed description of the plan. The description should separate the plan's unique features from required items and be written in a standardized format to be determined by a national entity.

Information such as fact sheets on each of the physicians in the plan, their training, years of practice, board certification, faculty responsibilities, and confirmed disciplinary actions such as repeated malpractice payments would be provided in this documentation. Fact sheets on individual hospitals with lists of services and other details should be available. The same type of information could be developed for home health agencies, laboratories, pharmacies and other contracted health providers.

4) Condition-Specific Provider and Practitioner Quality Report Cards including Enrollee Surveys

Condition or treatment specific information is important to the person who faces a major operation or health care decision and should be available upon request. This information is different from the plan specific information in that it includes both hospital and physician specific practice profiles and

outcomes data on a particular procedure or condition. This is similar to what has been done for coronary artery bypass graft surgery in both Pennsylvania and New York. The information could be presented either on a nation-wide or a region-wide basis and could be available from the national health board or its designees. The data should be appropriately adjusted for severity to avoid skewing outcomes for surgeons and hospitals serving a more vulnerable population. For a particular condition, this data could include:

- number of a surgeries performed (by hospital and by surgeon)
- death rates within certain time periods

Information obtained through the enrollee satisfaction surveys which addresses condition-specific provider and practitioner quality and outcomes should be part of this report card.

Conclusion

Consumer information must be developed with the consumers' needs in mind. Information should be available in written, verbal, and electronic forms. It will need to be available in different languages and forms for challenged populations. Independent health care counseling should be available to assist consumers when necessary. The success of health care reform is largely dependent on the ability of consumers to make wise choices and influence the quality and cost of health care. Therefore, the plans must provide the consumer with the necessary tools for good decision-making. This will require resources, but we believe it is a cost-effective investment over time.

Finally, good information and decisions alone will not ensure quality care. Quality assurance measures, grievance and appeals procedures, and independent, external entities must be in place to monitor quality and enforce standards.

The organizations that are working with the coalition stand ready to work with you on these and other consumer protection issues in health care reform.

June 26, 1993

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**Coalition for Consumer Protection and Quality
in Health Care Reform**

Draft White Paper on

Minimum Requirements for Consumer Information

Introduction

Consumer information is important in any health care system, but it is especially essential in a health care system based on managed competition. Managed competition assumes that consumers will stimulate high quality and low costs through their choices of health care plans and providers. For this to happen, consumers must have access to uniform and comprehensive information. The data collected by the health plans should be verified for accuracy on an ongoing basis by state or regional-level entities independent of the health plans or health alliances.

A national entity such as a National Health Board should be responsible for 1) establishing uniform data formats, 2) setting standards for collecting and analyzing data and 3) determining how the data should be distributed on the national, state and plan levels. It is essential that the data and information be accurate, reliable, comparable, timely, and easy-to-understand. It must also be available in different languages and formats for people with special challenges such as the visually or hearing impaired.

We want to make it clear, however, that even good consumer information will not eliminate the need for appropriate grievance and appeals procedures, internal and external quality assurance and external, independent quality oversight and monitoring of the health care system. In addition, consumers must be protected from unauthorized disclosure of any personal and individually identifiable information.

Summary

We believe that information available to consumers must be more than a "report card." A more appropriate description for what is needed is a "Consumer Guidebook" for plan selection and use. National standards should mandate what specific information will be provided in this guidebook and it should be readily available to every consumer.

The data should also be utilized to assist health care professionals in providing appropriate and effective care and enabling policy makers to fine tune the system to increase quality and reduce costs.

We envision four main categories of information:

June 26, 1993

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- 1) plan-specific descriptions including general information about the health alliance, the health care system and where to get help
- 2) plan-specific quality report cards—quality indicators reflecting a common set of performance measures and enrollee satisfaction
- 3) provider and practitioner-specific descriptions to help discriminating consumers choose a plan based on the background of specific doctors or services of a hospital
- 4) condition-specific provider and practitioner quality report cards to help guide the consumer to the best specialist or the best hospital for treatment of a specific condition.

1) Plan-Specific Description Information

If consumers are going to make informed choices, they need good understandable information describing plan configurations, how the health care delivery system works, how to use the consumer guide, how to appeal a health care decision, how to resolve complaints, and how to contact a health ombuds- or counseling program. Next, they will need to know the prices, benefits, and services of each plan option. The goal is to enable the consumer to compare health care plans in a given health alliance. The information should include descriptive and practical summaries presented in a comparative format.

Price, benefit and plan operation information could include:

Price Information:

- premiums, deductibles and co-payments
- cost or implications of using services outside the plan
- cost of coverage beyond the basic plan
- premium increase trend

Benefits, Plan Description and Policies:

- benefits covered
- services not covered by the plan
- time in operation
- membership size and percent in certain age groups
- number of physicians
- ratio of membership to primary care physicians
- ratio of physician to non-physician primary care practitioners

June 26, 1993

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- specialists available within the plan; outside the plan
- ratio of board certified physicians to non-board certified
- names of participating hospitals, home health agencies, laboratories, diagnostic facilities, pharmacies
- contractual relations between plans and providers
- plan policy regarding scheduling of routine annual physical exams, pre-natal visits, well-baby visits, immunizations
- plan policy regarding promptness of access for evaluation of symptoms
- plan policy regarding urgent care, hospitalization, length of hospital stays, specialist referrals, diagnostic procedures, mental health services, laboratory services, home health services, prescriptions
- plan policy regarding second and third opinions
- phone numbers for information specialist who can explain plan details

2) Plan-Specific Quality Report Cards—quality indicators reflecting a common set of performance measures and enrollee satisfaction surveys

The "report card" or quality measures and consumer satisfaction section of the consumer guidebook should compare the plans, providers, and practitioners in a given health alliance and, when appropriate, provide national averages for comparison. Areas that should be covered include enrollee access to care, quality of care, appropriate use of medical care, utilization rates, and the effectiveness of specific treatments and patient outcomes by diagnosis or procedure. Information about where to get assistance in interpreting the information and data should be provided to the consumer.

Performance Measures

Use of a common set of performance measures will not only provide consumers with good decision-making information, it will also enable health plans and providers to identify the best practices. The national health entity created to oversee the new health care system should also use the quality measures in the development and dissemination of clinical practice guidelines, the updating of the benefit packages, and the analysis of the cost-effectiveness of the health care provided.

It is expected that quality and its indicators will improve and evolve based on information from outcomes research. Required reporting of patient care encounters (presenting problem, diagnosis and treatment), and uniform patient identifiers to allow longitudinal records, should be considered. In addition, reporting of complications and hospital acquired injuries in the clinical record should be required. Clinical information will provide far more useful data than data extracted from billing codes (notably not available from managed care programs). Outcomes research studies should be conducted to

June 26, 1993

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evaluate the results of the health care process on the patients, including physiological measurements, functional status, and well-being or quality of life. This information should be made available to consumers, providers, and policy makers. These measures are essential for competition to succeed in improving and/or maintaining quality of health services.

The following types of information could be included in this section of the guidebook:

Preventive Care

Percentage of enrollees of certain age groups for whom appropriately timed preventive measures were provided or recommended, such as:

- health history interview and record
- annual physical and functional status assessment; urinalysis; blood hemoglobin, cholesterol (adult)
- childhood immunizations and boosters
- seniors: flu vaccination annually; pneumococcal vaccination one-time; boosters for tetanus and diptheria
- hepatitis b vaccine (for those with high exposure risk)
- tuberculosis screening
- colorectal screening
- mammogram screening
- gynecological exam and Pap smear annually (adult and/or sexually active females)
- prenatal care during 1st, 2nd, 3rd trimesters
- routine eye exams for seniors and diabetics

Indicators of undesired or unplanned occurrences, such as:

- inappropriate use of medications
- re-admissions within 30 days of post-surgery hospital discharge
- location-of-service acquired infections
- pressure ulcers occurring in patients confined to bed.
- injuries sustained at location-of-service: e.g., fractures, muscle contractures, harmful medication and treatment errors

Utilization of services related to service policy, such as:

- average time between first report of acute illness and examination
- average time between diagnosis and treatment of acute illness
- percent follow-up visit or phone call after acute illness
- average length of hospital stay: surgery, normal delivery, C-section, rehabilitation, mental health acute care
- number of referrals to specialists per primary practitioner

June 26, 1993

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- number of referrals for diagnostic procedures
- average time between diagnosis and various kinds of elective procedures

Consumer Satisfaction

A standard survey should be developed that will measure satisfaction among health plan participants. It could have some regional or otherwise appropriate individualized characteristics, but the main body of the survey should be consistent across the country so that it can be used for national comparisons. The survey should be short and clear and contain questions related to acceptability, availability and accessibility. It could include:

- overall satisfaction with care received
- degree to which questions were answered
- adequacy of treatment information
- did treatment alleviate symptoms
- convenience of location of doctors and hospitals
- number of specialists from which to choose
- number of primary care physicians from which to choose
- ease of obtaining desired referral
- attitude of staff and of physician
- length of time between making appointment and visit for symptoms; for preventive care
- length of time "on hold" before getting through to the plan
- length of time spent in the waiting room
- length of time spent with practitioner
- length of time between diagnosis and treatment
- availability of advice over the phone
- excessive paperwork or bureaucratic hassles
- willingness to recommend this plan to a friend

It should be mentioned that the New England Medical Center, Health Institute has developed an "Employee Health Care Value Survey" as part of the Health Plan Employer Data and Information Set, HEDIS, which looks quite promising.

Membership statistics

Membership statistics can also be indicative of consumer satisfaction and should be listed:

- number of new enrollees and dis-enrollees per year
- number of enrollee complaints

June 26, 1993

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3) Provider and Practitioner-Specific Descriptive Information

Further details on plans and their health care professionals should be provided on a per request basis. For example, if a consumer is trying to decide between Plan A and Plan B, he or she may want to review the detailed plan descriptions, which would be written in a standardized format with the plan's unique features set apart from items that the plans must contain. Information such as fact sheets on each of the physicians in the plan, their training, years of practice, board certification, faculty responsibilities, and documented disciplinary actions including repeated malpractice payments, should be provided in this documentation. Fact sheets about home health services, hospitals, laboratories and other contracted health facilities could also be developed. The health alliances or individual plans would supply this information.

Hospitals

Types of services provided, bed capacity and nursing services staffing of each type of unit:

- emergency department
- intensive care unit
- cardiac care unit
- general medicine and specialty units
- rehabilitation therapies
- surgery general and specialties
- obstetrics: delivery room, birthing room, operative procedures
- newborn care: normal newborn and intensive care nurseries
- radiology treatment and diagnostic capacity
- laboratory
- social services and discharge planning

Home Health Services

- skilled nursing and rehabilitative care
- hospice care services
- personal care aides
- home care equipment (e.g. oxygen, suction, special beds)

Out-patient Services

- urgent care
- diagnostic and follow-up care
- pharmacy services
- laboratory services

June 26, 1993

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Nursing home skilled care

- routine practitioner visits
- diagnostic services

4) Condition-Specific Provider and Practitioner Report Cards including Enrollee Surveys

Condition or treatment specific information is important to the person who faces a major operation or health care decision and should be available upon request. This information is different from the plan specific report card in that it includes both hospital and physician specific practice profiles and outcomes data on a particular procedure or condition.

For example, a consumer may want to know which hospital in the region (or the country) has the most experience in kidney transplants; which surgeon has the lowest mortality rate within that particular hospital or within a region; which hospital has the lowest mortality rate; which has the lowest post-surgery complication rates, and other factors. This is similar to what has been done for coronary artery bypass graft surgery in both Pennsylvania and New York. The information could be presented either on a nation-wide or a region-wide basis and could be available from the national health board or its designees. The data should be appropriately adjusted for severity to avoid skewing outcomes for surgeons and hospitals serving a more vulnerable population. Also, health counselors should be available for answering questions regarding this and other consumer information.

Information obtained through the enrollee satisfaction surveys which addresses condition-specific provider and practitioner quality and outcomes should also be available as part of this report card.

Confidentiality of Personal Information

With more emphasis on data collection and improved electronic data interchange, the risk of violating a person's right to privacy increases. Health care information often contain very personal information about physical and mental medical history, conditions and treatments.

The collection, storage, handling, and transmission of individually identifiable health care data should in no way infringe upon a person's right to privacy and to keep certain information confidential. National uniform standards should delineate very specifically what type of individually identifiable information may or may not be released without the person's authorization. Such standards should also delineate to whom confidential data may be released and for what purposes it may be used.

June 26, 1993

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In conclusion

Consumer information must be developed with the consumers' needs in mind. Information should be available in written, verbal, electronic forms, and in Braille and other languages to reach all populations. The success of health care reform is largely dependent on the ability of consumers to make wise choices and influence the quality and cost of health care. Therefore, the plan must provide the consumer with the necessary tools for good decision-making. Consumers need to know which provider offers the best services at the least costs, which practitioners have the most success with which treatments, and which hospitals are most likely to send the patient home without further complication. They also need protection against misuse of their personal records and information about where to go to file complaints, appeal a decision and get outside assistance by a health ombudsprogram or counselor. This will require resources, but they will undoubtedly pay for themselves over time.

Finally, good information and decisions alone will not ensure quality care. Quality assurance measures, grievance and appeals procedures, and an independent, external entity must be in place to monitor quality and enforce standards.

TESTIMONY OF SIDNEY M. WOLFE, M.D.

DIRECTOR, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP
 SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND
 TECHNOLOGY, COMMITTEE ON SMALL BUSINESS
 HEARING ON BARRIERS TO CONSUMER ACCESS TO HEALTH INFORMATION
 JUNE 28, 1993

History of Organized Medicine's Resistance to Public Access

Today's National Practitioner Data Bank battle and other battles between the public right and desire to know more about doctors in whose hands they entrust their lives and health versus organized medicine's wishes to keep secret such information has a long history.

Exactly 20 years ago, in July 1973, as the Health Research Group collected data from doctors in Prince George's County (in suburban Washington, D.C.) for what was the first doctor's directory for consumers in the United States, the Executive Director of the Maryland Medical Society successfully intimidated many doctors who were willing to give us information into non-cooperation by threatening them with loss of their medical license. Referring to then-existing state laws including one in Maryland, ultimately derived from the AMA's Code of Ethics, he said that any directory of doctors that contains "information that would point out differences between doctors " is prohibited by Maryland law.

More recently, a reporter for New York Newsday had to file a lawsuit against the New York State Health Department to obtain data showing doctor-specific differences in risk-adjusted coronary bypass death rates. The state argued unsuccessfully, on behalf of New York doctors, that disclosure of these data to the public constituted an "unwarranted invasion of the personal privacy" of the heart surgeons. The court soundly rejected this self-serving argument and the data were released and published.

Current Battle to Open the National Practitioner Data Bank

Thanks to implicit threats that the AMA would not support passage of the 1986 legislation which established the data bank, the valuable information which it contains is not only kept secret from patients but from doctors as well. If I want to refer Congressman Wyden or anyone else to another physician and wish to know if he or she has had their hospital admitting privileges suspended or restricted, has had one or more malpractice payouts against them or has been the subject of other disciplinary actions, I, as a physician with a fiduciary duty to my patients along with all of the patients who want to find out about this am excluded by law from obtaining doctor-identified information from the data bank.

Whereas we strongly support legislation to open the data bank, the American Medical Association's House of Delegates earlier this

month passed a resolution stating: "RESOLVED, That the American Medical Association...call for the dissolution of the National Practitioner Data Bank."

As we move rapidly towards the millennium and the twenty-first century, the American Medical Association is clearly acting in this instance as a crude, self-interested trade association no better than the many others poisoning Washington. By seeking the "dissolution" of the data bank, the AMA wants to protect the minority of American doctors about whom there is information in the data bank from the scrutiny of either their own patients or other physicians.

Data in the National Practitioner Data Bank as of June 18, 1993

The most recent report from the data bank, reflecting all data accumulated since it became operational on September 1, 1990 shows the following:

1. 6,435 practitioners (approximately 3/4 physicians and 1/4 dentists) have reports of adverse actions, including 7,065 state licensure actions (in some cases there is more than one action per practitioner), 2,660 clinical privilege actions (mainly loss or restriction of hospital privileges) and 119 professional society membership actions.

2. 41,556 practitioners have one or more malpractice payment reports in the data bank, 95.3% of these reports concerning physicians.

Examples of the Kind of Data in the Data Bank

The Public Citizen Health Research Group has been keeping its own data bank, based mainly on reports we obtain of state medical board actions. According to data received as of January 1992 the kinds of actions included probation, 22%, revocation, 14%, suspension, 13%, surrender of license, 10%, fine, 5%, reprimand, 5%, and other actions, 33%.

The 6,097 state disciplinary actions for which the states told us the doctors' offenses which had led to the actions included:

- * Misprescribing or overprescribing of drugs, 14%
- * Substandard care, incompetence or negligence, 11%
- * Personal history of drug or alcohol abuse, 10%
- * Criminal Conviction, 10%
- * Professional Misconduct, 7%
- * Providing false information to the board, 3%
- * Mental or physical impairment, 3%
- * Sexual abuse of or sexual misconduct with a patient, 2%

Despite the seriousness of many of these offenses, the licenses of the physicians who committed them are often neither revoked nor suspended and many of these doctors are practicing

medicine, seeing patients who are completely in the dark about what the state boards have concluded.

For the physicians found to be incompetent, negligent, or giving substandard care, 65% or 450 cases did not result in suspension or revocation and the doctors are still practicing.

For the offense of overprescribing or misprescribing of drugs, 71% or in 598 cases the doctors are still practicing. For personal history of drug or alcohol abuse, 76% or 484 doctors are still practicing and for criminal conviction, 38% or 385 are still practicing.

The point is not necessarily that the licenses of all or even most of these doctors should have been suspended or revoked--although for certain offenses some states are stricter than others--but the patients who go to these doctors have a right to know more about them than they read in the yellow pages or see on the diplomas on the doctors' walls. More fully informed means more protected.

Why public access to the data bank is important:

1. Patients need a full range of data in order to make informed decisions in choosing health care providers. This is especially important in the current reform climate that emphasizes consumers' role in the "marketplace" under all types of national health insurance proposals. Consumers currently have more information when choosing cars than doctors.

2. Physicians and others acting as "agents" of patients need a full range of data to make conscientious referrals to other providers. Such information would protect hospitals and other corporate entities by enabling them to screen out negligent colleagues whose actions could expose the entity to liability. Thus, the Data Bank should be viewed as a resource by the medical community rather than as a threat.

3. The importance of the ability to "shop around" is more than academic. Harvard studies estimate one percent of all hospitalized patients are injured or killed each due to physician negligence. Yet only a fraction of substandard doctors are penalized by state medical boards. By combining state board actions with other data, the Data Bank offers the best information available.

4. While some of the disciplinary information in the Data Bank is available through other sources, it is very difficult for most people to obtain. The Data Bank is the only resource that presents the whole spectrum of a provider's record, which is crucial to understanding the value of any individual action. In fact, the opportunity to view each action in context argues against claims that malpractice settlements will be inappropriately weighed by consumers or that the data will be otherwise misunderstood.

5. Public scrutiny increases accountability of the system, e.g. revealing incidents that should have been but were not reported to the Data Bank.

Why the Data Bank's function should not be left to the private sector:

1. A federal-level public program provides a single collection point for uniform data that the private sector could not achieve. Consistent nationwide data are valuable for many reasons, including consumer mobility, system-wide policy development and budgeting, quality oversight, etc.

2. Selective private sector distribution of "comparative" data is vulnerable to being used as an "advertisement" for the compiling entity, e.g. the recent "consumer report card" by United HealthCare Corporation, praised by Sen. Durenberger as a "model for industry [and] focus for national health care reform debate."

STATUTORY AMENDMENT FOR PUBLIC ACCESS TO THE DATA BANK

As currently drafted, Title IV of the Health Care Quality Improvement Act of 1986 deems all information submitted to the Data Bank "confidential" (except for information that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient), and places strict limitations on the use of such data. This means that members of the public, including other physicians, may not gain access to information in the Data Bank, and those that improperly release such information are subject to strict penalties.

The goal of this proposed amendment to the Act is to eliminate the current legal barrier to public access to the Data Bank. The amendment follows the current language of the statute as closely as possible, while shifting the focus from confidentiality of practitioner data to preserving the confidentiality of patients.

PROPOSED AMENDMENT

Delete current 42 U.S.C. § 11137(b)(1) in its entirety and replace it with the following:

Information reported under this subchapter that permits the identification of any patient is considered confidential and shall not be disclosed (other than to the physician, practitioner, or patient involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 11135 of this title (as specified in regulations promulgated by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a) of this section. Nothing in this subsection shall prevent the disclosure of such

information by a party which is otherwise authorized, under applicable state law, to make such disclosure. Information reported under this part that does not permit the identification of a patient shall not be considered confidential. The Secretary (or the agency designated under section 11134(b) of this title), on application by any person, shall disclose all non-confidential information reported under this subchapter.

Delete current 42 U.S.C. § 11137(b)(3) in its entirety, and renumber the following subsections accordingly.



Center for Patients' Rights

666 Broadway, Suite 410, New York, N.Y. 10012

Tel. (212) 979-6670 • Fax (212) 982-3036

LAURA WITTKIN

TESTIMONY OF THE
NATIONAL CENTER FOR PATIENTS' RIGHTS
BEFORE
THE SMALL BUSINESS SUBCOMMITTEE ON REGULATION,
BUSINESS OPPORTUNITIES AND TECHNOLOGY

JUNE 28, 1993

Good morning, my name is Laura Wittkin. I am the Executive Director of the National Center for Patients' Rights (CPR), a malpractice victims' and patients' rights advocacy and support group. Thank you for inviting us to participate in this hearing today to examine the need for consumers to make informed choices about their practitioners, providers and health care plans. It is an issue which is of paramount importance to anyone seeking medical care in the United States, today.

The Center for Patients' Rights assists victims and concerned medical consumers throughout the country. We have chapters in New York, Massachusetts and West Virginia, and, on average, CPR receives 200 phone calls a week. Eighty-five percent of those calls deal with patients who have been harmed by poor care. These individuals are not only seeking victim support and guidance about how to file complaints or pursue their legal rights, they are often desperately ill and in need of immediate medical attention but don't know where to turn. They have lost faith in the profession, and in their own ability to judge whether a practitioner is competent or not.

But no matter why people contact us initially, in the end, most consumers share a common frustration and apprehension about the lack of public access to quality-related information about doctors, hospitals and health plans. They contact our group hoping we can direct them to a good doctor or hospital or show them how they can find one themselves. But unfortunately, for the most part, we can't.

The reality is that despite the fact that we live in one of the most technologically and scientifically advanced countries in the world, it is virtually impossible for consumers to find out about the quality of a health care provider. And although this may sound like a cliché it's true, we DO know more about the quality of our toasters and T.V.s than we do about the doctors and hospitals in whose hands we place our lives and the lives of our loved ones.

Trying to uncover information about a doctor's background often requires the skill, training and perseverance of a detective.

When people call to check on a doctor's background they are generally interested in:

- o Malpractice actions
- o Hospital Disciplinary actions
- o Medical Training
- o Skill and expertise in certain procedures
- o Medical Board Disciplinary actions
- o Board Certifications
- o Hospital Affiliations

Before walking a caller through the many steps they must take to gather some of this information, we forewarn them that most of the information a patient needs to make an informed decision about his or her practitioner, is either unavailable, fragmented and incomplete.

CHECKING ON A DOCTOR:

Medical Board Disciplinary Actions:

After issuing that caveat, we suggest they start by calling their State Medical Board, which many people are still unfamiliar with. Depending upon what state someone lives in, they may find out when the doctor was licensed, if he or she is currently registered to practice, what school they went to, and whether or not their licensure is in good standing. But that's the easy part.

If they want to find out if the doctor has been disciplined by the state, they must specifically ask or it will not be volunteered. If they phrase the question improperly, as most people do, they will receive inaccurate information. For example, most people, unfamiliar with the terminology, ask if a doctor has any complaints against his or her license, instead of disciplinary actions. Complaints are confidential in virtually all states until they have been acted on, or in some states, closed. Therefore the answer to a question phrased that way, will always be either "NO", or "THAT INFORMATION IS NOT AVAILABLE TO THE PUBLIC". And at that point, most people will not pursue the matter further.

If they only ask if a doctor's license is in good standing, and that doctor had just had a revoked license restored or come off of a suspension or probation, the answer will be "YES, THAT DOCTOR'S LICENSE IS IN GOOD STANDING". Therefore, we always instruct consumers to not only ask if the license is in good standing, but to ask if a doctor HAS EVER been disciplined by the state. If the answer is affirmative, they must generally make a request in writing in order to find out why the doctor was disciplined. The requests can take weeks to process and there is a fee for photocopying, which can be expensive depending on how voluminous the file is and how many doctors you are requesting information on.

Approximately, one half of the medical boards in the U.S. provide information about doctors who have been formally charged with medical misconduct, meaning a complaint was investigated and grounds were found to initiate a misconduct proceeding. This is a vital piece of information because it often takes years for a doctor to move through the discipline process. During that time, most doctors are usually allowed to continue practicing, leaving their unsuspecting patients vulnerable to harm. Again, we instruct consumers to specifically ask this question, because the information will not be volunteered. And the vast majority of these states will not tell you the reason for the misconduct charges, unless you send a request in writing.

On top of everything else, many consumers who attempt to contact state medical boards often have great difficulty getting through. More times than not, they simply give up. State medical boards are definitely NOT user friendly.

Board Certifications:

In addition to checking with the medical boards, we suggest that people check to see if their doctor is board certified with one of the 23 recognized board specialties in the country. There is a national toll free number, that you can actually get through to, which will provide you with this information.

But we caution against placing too much value on this fact alone. We have found that even if a doctor is board certified they are not regularly recertified. And according to a GAO report, board certified doctors are sued for malpractice as often, if not more often, than non-Board certified doctors.

We also suggest that people pay close attention to a doctor who has a board certification from an unrecognized Board. That is something they should certainly investigate further.

Hospital Affiliations:

If a consumer wants to find out what hospital a doctor is affiliated with, we recommend that they ask the doctor directly. Where a doctor has privileges may indicate something about the doctor's competence, but not always. We also recommend that the person call the hospital themselves to confirm that the doctor actually does have privileges. Unfortunately, we have seen too many cases of dangerous doctors unable to get privileges, who operate out of these boutique "butcher" shops, and routinely lie to their patients about their hospital affiliations.

Malpractice Actions:

Checking on malpractice actions against doctors is also a daunting and often undoable task. Depending on what state you live in or even what part of the state you live in you may or may not be able to research a doctor's malpractice history.

There are a handful of state boards in the country that do make some malpractice-related information public. But again, you must know to ask about this or you won't be told. One state might just tell you the number of times a doctor has been sued, another might only tell you about CLOSED malpractice cases, but, of these few states, most will not tell you anything specific about the nature of the malpractice action. Some may give you this information over the phone, others may require that you put your request in writing. And some states, like Massachusetts, do not keep their malpractice information current, so when a consumer calls to find out about lawsuits against a doctor, they may be given misleading and potentially harmful information.

In our experience, most people end up having to do courthouse searches, which are enormously time consuming and often disappointing. There is no consistency in the way courts file cases. Some may file cases by plaintiff only, some by defendant only and others may cross-reference. The New York state court system is a perfect example of this inconsistency.

If you live in parts of upstate NY it is relatively easy to do a courthouse search because cases in those counties are filed by defendant or cross-referenced. In New York City, however, where most of the state's malpractice occurs, we are unable to find out the malpractice history of a doctor because cases are filed by plaintiff only.

Generally, we tell people to begin their search by calling the civil courthouse in the area in which the doctor practices. We instruct them to speak to a clerk in the record or docket room to ask how their cases are filed. If they are filed by plaintiff only, it will be almost impossible to locate the malpractice actions against the doctor, unless someone has weeks or months of spare time to devote to the search. If the court files cases by defendant or cross-references cases, then we suggest that they go down to the courthouse record room to see if there are any cases against the doctor. (They will not provide you with this information by phone.) If the court system is on computer, they may simply punch in the doctor's name to see if any cases come up. If there are cases against the doctor, we suggest they copy down the case numbers and ask the clerk to pull the file in order to find out about the nature, seriousness and status of the malpractice action.

If the court does not have a computer system, they would have go through volumes of books, which list cases alphabetically (by defendant), by year. Some courts keep malpractice cases in separate books, others do not. We suggest that anyone doing a search go back at least 7 years to get a sense of whether or not there may be a pattern of bad care. In some cases they may find no suits, in others, they may find 1 in seven years which was not of a serious nature, or they may find a sudden cluster of recent suits.

But the problem with courthouse searches is that they might not always provide you with accurate information. For example, if a doctor has been sued along with a hospital, or as part of a medical corporation or with other defendants, the suit may not be filed under his or her name (Although many courthouses do TRY to cross-reference those types of cases).

Also, if the doctor practices in more than one county, or has moved from one part of the state to another, that is generally something consumers are unaware of, and any suits filed outside their immediate county would not be found in their local courthouse. In addition, if a doctor has moved from another state, (which is also something the public would generally not be aware of) you may end up missing a very important piece of the malpractice profile.

Hospital Disciplinary Actions:

Trying to find out if a doctor has had problems in a hospital is nearly impossible unless the problem resulted in a lawsuit or an action by the state medical board. Quality Assurance and Risk Management departments in hospitals often contain vital information about the competence or skill of a practitioner but, by law, the public is denied access to the information.

Even when Federal, State or private hospital oversight agencies step in and uncover wrongdoing on the part of a doctor, the doctor's name, along with any quality assurance review information, is always redacted in the reports that are released to the public.

Hospital disciplinary actions are also unavailable to the public, which presents a critical problem for many consumers. The fact is that many doctors who lose privileges in one hospital are still able to practice in other facilities, placing unsuspecting patients at risk. Usually, consumers only find out that a doctor was kicked out of a hospital, if the medical board takes an action against the doctor's license. But medical boards often take years to act on these cases, and all the while that doctor is out there practicing.

CHECKING ON A HOSPITAL:

Trying to find out about the quality of a hospital makes checking on a doctor's background look simple. Generally, there are two things consumers want to know about hospitals: What it is they do exceptionally well, and whether or not they are known to have problems providing competent medical care.

Outcome Data:

Although we are hearing more about outcome data on procedures and providers, there is currently still very limited data available to help consumers identify which hospitals have better services in certain areas than others. But outcome data developed by Pennsylvania, New York, California and some other states look very promising. In fact, New York state's release of the Open-Heart Surgery data over the last three years has already proven to be beneficial to medical consumers.

The risk adjusted data tells how many patients have died, how many were expected to die and whether the doctor and hospital's performance was above or below that number. This information has allowed patients to make better informed choices about where to get their surgery done and by whom. The public release of this data has also encouraged those facilities which did not rank well in the first year, to take the necessary steps to improve their performance. The result has been an overall decline in heart surgery mortality in the state of New York. One of the problems with this data, however, is that is not widely available. Most consumers still do not know the data is out there, and we have heard complaints about some doctors and hospitals that have refused to provide this information to a patient upon request. Well-researched information can be a powerful tool, but it must be able to reach those who need it.

The JCAHO and the Federal PRO's are also beginning to explore ways to look at outcome data, but at this point procedure-related data is still in its infancy and will take years to fully develop.

Hospital oversight agencies:

Beyond looking at outcome data as measure of the quality of a hospital, there is not much other easily available or reliable information for consumers to access about a hospital, even though facilities are regulated by a variety of federal, state, and private oversight agencies. And most of the surveys results and findings generated by these agencies are either confidential or difficult to obtain.

CHECKING ON A HEALTH PLAN:

For people interested in learning more about a health plan, there is not yet a lot of information to direct them to. If we know that a private, state or city agency has done a report or survey on managed care plans, we will direct them to that information. We also suggest some generic things to look out for and question. Beyond that, we have really just begun to get involved in this area.

HEALTH CARE REFORM:

If the Clinton administration's health care reform model does become a reality in this country, informed consumer choice will play a key role in assuring and improving the quality of health care in the U.S.

Under this model, which emphasizes cost control and strips away our freedom to choose our own practitioners and other providers, it is essential for consumers to have access to information about the quality of their providers' care. This data will enable us to better identify those doctors who would be most appropriate for our needs.

It is not acceptable for employer's, alone, to have access to this comparative data. Too often an employer's or health plan's bottom line is money, but a consumer's bottom line is ensuring the quality and skill of the practitioner or provider. And health care is too important an issue to have a middleman.

And even though the idea of comparative data is new, the idea of keeping data out of the hands of consumers, unfortunately, is not. In New York state there are already obstacles being placed in the way of getting the Open-Heart data into the hands of the public. Doctors, it seems, are hard at work looking for a way to shield the individual practitioners' names. If they are ultimately successful, it will dramatically diminish the usefulness of that data, and prevent consumers from making informed choices about their care and treatment. We continually hear that consumers need to take more responsibility for their health care — Having access to this information is one direct way that we can do that.

The National Practitioners' Data Bank:

In addition to having access to comparative outcome data, consumers must be allowed to have access to the information maintained in the National Practitioners' Data Bank. It is clear that we cannot rely on our medical boards, our hospitals or the any other oversight programs, alone, to protect us from dangerous practitioners.

And all of the of the information collected by the Data Bank is vital to consumers. Medical board actions, by themselves, would not be useful because so few dangerous doctors are disciplined. Either would just malpractice actions, because, again, you are not getting the entire picture. Nor can we rely solely on hospital disciplinary actions since so few doctors are ever disciplined by hospitals. The various pieces of information in the data bank compliment one another and help provide a useful profile on a practitioner.

In our testimony today, we have attempted to outline how unbelievably difficult it is for most of us to get information about doctors. Most of that information, however, is easily available through the Data Bank and to deny consumers access to that information would be criminal. The paternalistic attitude of the medical profession, in denying consumers access because we supposedly would not know how to interpret the information, is self-serving and ridiculous. As we stated earlier, most of the information in the data bank is already publicly available, just not easily or consistently available. Being able to access this information from a centralized base will save time, money and, most importantly, lives.

Role of the Federal Government In Facilitating Access to Information:

As we move into a new age of health care delivery in this country, our government must strive to create the best possible system with accurate comparative data that has been properly risk-adjusted, and they must ensure that the public is not left out of the process. It is essential that both outcome data and information collected by the Data Bank be available on-line and easily accessible through libraries, hospitals, doctors' offices, health plans, universities, or by phone.

Our government must also make certain that there are ongoing public outreach and education programs to teach consumers how to make the most of the data, what their rights are, and how to exercise their rights in the new health care model, (whatever model that turns out to be).

We have a growing epidemic of medical malpractice in this country, which claims at least 90,000 lives each years, and leaves hundreds of thousands seriously injured, yet over the last decade there has been no real improvement in the quality of health care. How many more families will have to endure the horror and tragedy that the Bennett family did? Or the loss and abuse that the Miller's were subjected to? And how can we consider such a dramatic change in our health care system, without **first** placing quality at the top of our health care agenda?

Our legislators and government officials must recognize and support the need for consumers to be empowered with information to protect themselves from dangerous practitioners, and to make the best possible choices about their health care.



American Dental Association

STATEMENT
OF THE
AMERICAN DENTAL ASSOCIATION
ON
INFORMED CONSENT: THE ROLE OF CONSUMER CHOICE
IN IMPROVING THE QUALITY OF HEALTH CARE
BEFORE THE
REGULATION, BUSINESS OPPORTUNITIES, AND
TECHNOLOGY SUBCOMMITTEE
COMMITTEE ON SMALL BUSINESS
JUNE 28, 1993

Washington Office: 1111 14th Street NW Washington DC 20005 (202) 898-2400

Thank you, Mr. Chairman, for the opportunity to provide the subcommittee with the American Dental Association's position regarding disclosure of the information in the National Practitioner Data Bank (hereinafter "Data Bank") to the general public with the intent of providing consumers with information necessary for them to choose quality health care providers. The Association applauds the chairman for his efforts to assist consumers in selecting quality practitioners, but we very strongly oppose disseminating information from the data bank to the public as a means of accomplishing that goal.

The ADA has long endorsed and encouraged patient freedom-of-choice when selecting a dentist. In fact, our position with regard to increasing access to dental care is based on an expansion of the existing dental care delivery model, which has successfully relied on provider competition and accountability to help contain costs.

The Association is taking a firm position in opposition to public disclosure of the Data Bank information because much of the data in the system, especially with regard to dentistry, is flawed. Providers could have their reputations unfairly harmed with no opportunity to defend themselves in a public setting. The public could be misinformed without a means of distinguishing accurate from inaccurate data.

To cite an example - the Data Bank regulations require dentists to report fee refunds as malpractice payments. The Data Bank makes no distinction between fee refunds, commonly given by many professionals (not just physicians and dentists) as a courtesy to their patients or clients, and malpractice payments, paid in a lawsuit where negligence has been established.

Some common examples of refunds not involving negligence are: an attorney gives a refund to maintain goodwill in instances where the client believes he or she has overpaid for the service; an optometrist refunds money to a patient whose eyes failed to adjust to recently purchased contact lenses; and an orthodontist refunds a pro rata portion of the patient's treatment payment plan when the patient moves before care has been completed.

The above cited examples clearly do not involve malpractice, but only the attorney can be assured that the refund given to retain client goodwill will not be mislabeled as a "medical malpractice payment" because attorneys are not covered by the Data Bank. On the contrary, the orthodontist who refunds a portion of his patient's pre-paid treatment payment plan must report such refund as a "medical malpractice payment" whenever it is given in response to a written request. A consumer receiving information regarding

a given dentist or other covered health care provider would be unable to identify which "medical malpractice payment" reflects negligence and which represents a commercial accommodation in an effort to maintain patient goodwill.

The likely results are detrimental to the consumer, but especially to the dentist, who may experience short and long term adverse effects on his or her reputation and practice. The inquiring consumer looking for a dentist will be harmed because he or she will avoid a potentially excellent practitioner who is concerned about maintaining patient goodwill. The immediate harm to the dentist is loss of the inquiring consumer as a patient. The long term impact may be considerably more as the dentist will be unfairly stigmatized each time that data is given to another individual, jeopardizing the practitioner's reputation and career.

A dollar-specific reporting threshold would eliminate a number of the meritless small claims and also resolve many of the problems caused by the mislabeling of fee refunds, as discussed above. Pursuant to 42 USC section 11131 (d), the Secretary is directed to file a report with Congress concerning the need for reporting information respecting small medical malpractice payments. In a December 16, 1992 letter to this Association, Dr. Louis Sullivan, as Secretary of the Department of Health and Human Services, stated that he was "...supportive of a \$30,000 threshold for the reporting of medical malpractice payments".

Dr. Sullivan stated that "... a persuasive case can be made for a dollar-specific reporting threshold both because lower-dollar payments appear less likely to point to serious problems, and because a threshold may reduce malpractice litigation, the cost of which is added to the health care system." Unfortunately, Dr. Sullivan's letter was not forwarded to the 102nd Congress before it adjourned, but his decision was well reasoned and should be considered by the present Administration and this committee.

The Association opposes opening the Data Bank to the public also because most private citizens do not have the background necessary to properly interpret the information in the record, which lacks sufficient specificity to permit the uninitiated to conduct a fair evaluation. The Energy and Commerce Committee recognized this fact as it stated in the legislative history accompanying the enabling legislation that "... malpractice data provide only clues, not conclusions. Any number of considerations other than the merits of a claim can affect the size and frequency of malpractice payments." (H.R. REP. No.903, 99th Cong., 2nd Sess. 13 & 14, reprinted in [1986] U.S. CODE CONG. & AD. NEWS 6396)

In fact, liability insurance carriers often settle nuisance complaints in order to avoid the cost of litigation, even when the claim is meritless. Such settlements are commonplace. Unfortunately, providers frequently are not permitted under the terms of their insurance policies to withhold permission to settle,

even if the suit is meritless, in instances where the companies determine it is in their financial best interests to settle. The settlement information, regardless of the circumstances, is reported to the Data Bank as a "medical malpractice payment."

In an effort to ameliorate the adverse consequences of improper use of the data, the Committee limited access to "knowledgeable" individuals. Specifically, it stated that: "The Committee is confident that those authorized under this bill to gain access to this information will have the awareness and sensitivity to use it properly." (Id.) (Emphasis added) Furthermore, the law "... does not necessarily require extensive descriptions of the acts or omissions nor of the injuries or illnesses upon which the action or claim was based. It does, however, require sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action or claim." (Id.) (Emphasis added)

Clearly, the Committee was aware of the potential for harm if the raw information in the Data Bank was released to unauthorized persons. They lack the requisite knowledge to properly interpret the data, and would often be hampered by insufficient specificity in the record. The Association believes this remains a valid conclusion today.

The ADA also believes that the Data Bank information should not be released to the public because it is not clinically reliable information. It is simply raw data, without any meaningful reference to the facts surrounding the situations reported, such as the severity of the cases in question or the case mix of the affected practitioner. As a result, the consumer is unable to put the information in context and may reach an invalid conclusion - that the dentist is incompetent.

No one, much less an untrained individual, could make an informed decision regarding the competency of a provider by merely reviewing that practitioner's "medical malpractice payment" record. But that is what will occur. Physicians and dentists with even a single entry will suffer discrimination and will lose potential patients, even if the entry is a mislabeled fee refund.

Some have asserted that physicians and dentists should have access to the data for all practitioners in order that they can make better informed referrals. The Association believes this rationale is based on the faulty premise that the doctors are unaware of the competency level of the practitioners being referred. It is, of course, common practice for doctors to refer their patients only to colleagues who are professionally, and often personally, well known to them.

Other problems will arise if the data bank is open to the public. There will certainly be a considerable increase in litigation, and law suits will become more costly, complex and difficult to resolve as practitioners try to avoid the stigma of becoming a Data Bank statistic.

In addition, inquiries from practitioners to review their records will increase significantly , potentially overloading a system which cannot provide timely service under the present circumstances. Finally, there will be a demand for better dispute resolution procedures than is provided under the current law in those instances when the practitioner disagrees with the Data Bank information.

In summary, the Association strongly opposes the dissemination of Data Bank information to the public. Providers will have their reputations unfairly harmed and the public will be misinformed. The current system, which fails to distinguish between fee refunds and true malpractice payments, would cause even greater problems for dentists concerned about maintaining patient goodwill. The Committee recognized in 1986 when the enabling legislation was passed that only those authorized under the bill should have access to the data bank information, as only they would have the "... awareness and sensitivity to use it properly." We agreed with that decision in 1986 and it holds true today.

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